Orthopaedic Trauma & Fracture Specialists
Medical Corporation

3750 Convoy Street, Suite 201
San Diego, CA 92111
Tel: 858-278-8031
Fax: 858-278-1708

Orthopaedic Traumatologists
Board Certified in Orthopaedic Surgery

REGISTRATION INFORMATION

☐PVT ☐PPO ☐M-CAL ☐M-CARE ☐HMO ☐CHAMPUS ☐CASH Date: _____

Patient's Full Name: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Wk Phone: _____ Other: _____ Email: _____

Marital Status: _____ Date of Birth: _____ Age: _____ Sex: _____ Social Security: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Referred By: _____ Primary M.D. _____ Telephone: _____

Insured Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Wk Phone: _____ Other: _____ Email: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

____ **Sharp Memorial EA**

Primary Insurance: _____ ID#: _____ Group#: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Copay $: _____

Secondary Insurance: _____ ID#: _____ Group#: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Copay $: _____

Attorney: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Telephone: _____

Have you ever been seen in this practice before? Yes ☐ No ☐ By: _____ When: _____

I understand that patients who carry medical insurance should remember that professional services are rendered and charged to the patient, not the insurance company. In the event insurance payments are received directly by me for services rendered that have not been paid for, I promise to immediately sign over and forward those payments to the doctor. I accept financial responsibility for all charges incurred. I understand that statements are due when presented to me by Orthopaedic Trauma & Fracture Specialists Medical Corporation or when transferred to me by my insurance carrier and that a late payment charge of 1% per month applies to overdue balances. If my account has to be referred for outside collection I will be charged a service charge. AUTHORIZATION: I hereby authorize payment directly to Orthopaedic Trauma & Fracture Specialists Medical Corporation for medical services by that entity, and to release any information acquired in the course of my examination or treatment to my insurance company.

Patient's/Guardian's Signature X _____ Witness Signature _____