ORANGE COUNTY ORTHOPEDIC CLINIC

3420 Bristol Unit #750-B Costa Mesa, CA 92626	(800) 226-4831

Date: _______________________________________

Patient Full Name____

Male **Female** **Date of Birth** _____________________ **Age** _______________

Home Address______________________________________City_______________Zip Code________

Home Phone (___) _____ _____ **Cell Phone (____)** _____ _____ **Work Phone (____)** _____ _____

Patient ____ **Mom** ____**Dad** ____**Employer**______________________**Occupation**__________________

Employer Address________________________________City_______________Zip Code ___________

PATIENT'S Social Security #_____________________**Patient's/Parent's DL#**_______________________

Name of Emergency Contact ____

Relationship to you ______________________________________ **Contact Ph# (____)** ______ _______

Insurance Plan Name______________________ **ID#** _______________________ **Group#** __________

If HMO, Medical Group name ____

Policy Holder Name___________________________________ **Relationship to you** _________________

Policy Holder Date of Birth ________________ **SS#** ____

Referred by? ________________________ **Injury/onset date** _____________**Work Related?**_________

I/WE HEREBY AUTHORIZE ORANGE COUNTY ORTHOPEDIC CLINIC (______________________________) TO EXAMINE OR TREAT AS DEEMED NECESSARY FOR THE CARE: (SEE ABOVE NAMED PATIENT), AND I/WE AGREE TO ALL FINANCIAL OBLIGATIONS INCURRED FOR CARE.

PATIENT / PARENT / GUARDIAN SIGNATURE ____

www.orangecountyorthopedicclinic.com