DAVID W. HANKIN, M.D.
WILLIAM B. HEYERMAN, M.D.
RICHARD N. CROSS, M.D.
WILLIAM J. SNIDER, M.D.

REDDING ORTHOPEDIC CENTER

REGISTRATION
COMPLETE ALL PORTIONS
- Please Print -

CHART No.

TODAY'S DATE: Mo. Day Year

REFERRING M.D. _____ and/or FAMILY M.D. _____

Have you ever been treated by one of our doctors? ❒ YES ❒ NO By Whom? _____

DOCTOR: _____

PART OF THE BODY TO BE TREATED? _____

Patient's Name: _____ (Last First Middle) SEX: _____ DATE OF BIRTH: _____ AGE: _____

MAILING ADDRESS: _____ (Street or Box Number City State Zip) TELEPHONE: _____

MARITAL STATUS: *(check one)* ❒ Married ❒ Unmarried ❒ Separated ❒ Widow ❒ _____

PATIENT'S SOCIAL SECURITY NO. _____

Patient's Employer: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ (Street or Box Number City State Zip) EMPLOYER'S PHONE: _____

_____ (Name of Insurance Company) POLICY or GROUP NO. _____ I.D. NO.: _____

Husband's or Wife's Name: _____ SOCIAL SECURITY NO. _____

Husband's or Wife's Employer: _____ OCCUPATION: _____

Husband's or Wife's Employer's Address: _____ (Street or Box Number City State Zip) EMPLOYER'S PHONE: _____

Secondary Ins. _____ (Name of Insurance Company) POLICY or GROUP NO. _____ I.D. NO.: _____

Husband's or Wife Address if different from Patient's Above: _____ (Street or Box Number City State Zip) PHONE: _____

If patient is a child under the care of a parent or guardian, please complete:

FATHER'S NAME: _____ PHONE: _____

FATHER'S ADDRESS: _____ SS# _____

FATHER'S EMPLOYER: _____ PHONE: _____

FATHER'S EMPLOYERS ADDRESS: _____

MOTHER'S NAME: _____ PHONE: _____

MOTHER'S ADDRESS: _____ SS# _____

MOTHER'S EMPLOYER: _____ PHONE: _____

MOTHER'S EMPLOYER'S ADDRESS: _____

INJURY:
HOW DID IT HAPPEN? _____ DATE OF INJURY: _____

WHERE? _____

INDUSTRIAL:
DID INJURY OCCUR ON-THE-JOB? ❒ YES ❒ NO DATE OF INJURY: _____ CLAIM NO. _____

EMPLOYER AT TIME OF INJURY: _____

EMPLOYER'S WORKMEN'S COMPENSATION INSURANCE CARRIER: _____

MEDICARE/MEDI-CAL

IS VISIT COVERED BY:

**You must have your Medi-Cal card for treatment.*

Medicare	❒ YES	❒ NO	I.D. NUMBER _____
Medi-Cal*	❒ YES	❒ NO	I.D. NUMBER _____
Shasta County Medical Assistance Program	❒ YES	❒ NO	I.D. NUMBER _____

RELATIVE or FRIEND'S ADDRESS: _____ (Give name of nearest relative or friend - not living with you.) RELATIONSHIP: _____

_____ (Street or Box Number City State Zip) TELEPHONE: _____

PAYMENT OF BENEFITS

I authorize payment of benefits, as determined by the Company, directly to:
Surgeon/Physician ❒ YES ❒ NO
I understand that unless I have checked "Yes" above, benefit payments will be paid to me. I also understand that even if I have checked "Yes" above, I may still be responsible for any amounts not paid by my insurance company in the event that the charges made are not within the insurance company's definition of reasonable and customary.

Signature _____ Date _____

MEDICAL RELEASE AUTHORIZATION

Injured party must sign for all claims. Dependent patient must also sign if not a minor. Iauthorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any nformation requested with regard to processing my claim. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature _____ Date _____

Signature _____ Date _____

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

- ***PATIENTS ARE RESPONSIBLE FOR BILLING THEIR OWN INSURANCES*** -