



MARIN
ORTHOPEDICS &
SPORTS MEDICINE

**Marin Orthopedics & Sports Medicine
PATIENT REGISTRATION FORM**

_____	_____	_____	_____
Last Name	First Name	MI	Today's Date
_____	_____	_____	_____
Social Security Number	Date of Birth	Age	M/F
_____	_____	_____	_____
Address	City	State	Zip
_____	_____	_____	_____
Home Phone	Cell Phone	Business Phone	
_____	_____	_____	
Occupation	Employer	Who referred you to our office?	

Parent / Guardian / Emergency Contact Information: (must fill out if patient is less than 18 years of age)

_____	_____	_____	
Name	Relationship to Patient	Phone #	
_____	_____	_____	
Address	City	State	Zip
_____	_____		_____
Insurance Carrier Name	Subscriber Name/SSN	Date of Birth	

I authorize payment of medical benefits to the undersigned physician or supplier for services provided. I authorize the release of any medical record(s) or other information necessary to process this claim.

Records Release: I hereby authorize you to release to any physician, hospital, insurance company, employer, or attorney any information requested regarding my present or past injury or illness.

ACKNOWLEDGMENT OF UNAUTHORIZED VISIT & PAYMENT RESPONSIBILITY
This is an acknowledgment, the above-named patient wishes to be seen/treated by Marin Orthopedics and Sports Medicine or any other designated provider, despite the fact that he/she may not have a referral/authorization for this visit. As the subscriber/responsible party for payment of this service, I understand that my insurance company may not pay for this visit and/or any service rendered which I am ultimately responsible for the total amount due for this visit. Regardless of insurance, accounts are due upon receipt and must be paid within 60 days. I have received and read a copy of the Notice of Privacy Practices (HIPPA).

_____	_____	_____
PRINT NAME	SIGNATURE	Date