

# Chico Orthopaedic Surgery & Sports Medicine

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## Patient Registration

### PLEASE PRINT

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Middle Name: \_\_\_\_\_

Previous Last Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security No: \_\_\_\_\_  
Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
Mobile Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

How Did you hear about us: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

### Emergency Contact Information

Name: \_\_\_\_\_  
Relation: \_\_\_\_\_  
( ) \_\_\_\_\_ - \_\_\_\_\_

### Next of Kin

Name: \_\_\_\_\_  
Relation: \_\_\_\_\_  
( ) \_\_\_\_\_ - \_\_\_\_\_

### Patient Employer Information

Name: \_\_\_\_\_  
( ) \_\_\_\_\_ - \_\_\_\_\_

### Guarantor Information (to whom statements are sent)

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Middle Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Employer Name: \_\_\_\_\_

## Primary Insurance Information

### Policy Information

Patient's relationship to policy holder: \_\_\_\_\_  
ID/Certification No: \_\_\_\_\_  
Policy/Group No: \_\_\_\_\_  
Issue Date: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Policy Holder

Type of Insurance: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Middle Name: \_\_\_\_\_  
Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Secondary Insurance Information

### Policy Information

Patient's relationship to policy holder: \_\_\_\_\_  
ID/Certification No: \_\_\_\_\_  
Policy/Group No: \_\_\_\_\_  
Issue Date: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Policy Holder

Type of Insurance: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Middle Name: \_\_\_\_\_  
Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

All Fees whether they are covered by Insurance or not, are due and payable within 30 days unless other arrangements have been made. A service charge is applicable and warranted after this period, regardless of insurance status. It could be either 1 1/2% per month (18%) annual percentage rate, or a minimum charge of \$.50 cents. I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for all noncovered charges. I authorize the physician to release any information required by other physicians or agencies for the purpose of reimbursement to my account or pending treatment deemed necessary by my physician.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_