

# Chico Orthopaedic Surgery & Sports Medicine

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## Patient Registration

### PLEASE PRINT

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

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Sex: \_\_\_\_\_

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security No: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Zip: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Mobile Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Marital Status: \_\_\_\_\_

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

\_\_\_\_\_

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

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

### Emergency Contact Information

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

### Next of Kin

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

### Patient Employer Information

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

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

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

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Address: \_\_\_\_\_

Zip: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

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 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: \_\_\_\_\_