

Patient ID: _____

Patient Name: _____
First Middle Last Sex:

Date of Birth: _____ Age: _____ SSN: _____

Language: _____ Race: _____ Ethnicity: _____

Marital Status: _____ Home #: _____ Cell #: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Patient Employer: _____ Occupation: _____

Do you have an Advanced Directive? (Examples: DNR, Living Will, Power of Attorney):

☐ Yes, on File ☐ Yes, I will bring a copy ☐ No, would like more information ☐ No, not interested at this time

Primary Ins Name: _____

Policy Holder Name: _____

Relationship to Policy Holder: _____

ID #: _____ Group #: _____ Subscriber DOB: _____

Secondary Ins Name: _____

Policy Holder Name: _____

Relationship to Policy Holder: _____

ID #: _____ Group #: _____ Subscriber DOB: _____

☐ I would like to receive text message reminders (Standard text rate messaging and data rates will apply)

I assign and authorize payment for any & all services rendered to OCSRI from my insurance company or third-party payor. I agree to pay all charges not covered by my insurance including but not limited to deductibles, co-payments, and non-covered services. I hereby authorize release of pertinent information to my insurance carrier(s). This order will remain in effect until revoked by me in writing.

Signature: _____ Date: _____