



OSMS REGISTRATION FORM

ALL OF THE FOLLOWING INFORMATION IS REQUIRED FOR INSURANCE FILING PURPOSES. EACH ITEM MUST BE COMPLETED IN ORDER FOR OUR BILLING STAFF TO FILE YOUR INSURANCE. FAILURE TO SUPPLY ALL REQUIRED INFORMATION COULD RESULT IN THE PATIENT HAVING TO PAY THE BILL IN FULL. PLEASE PRINT.

DATE _____ HOME PHONE _____

~PATIENT INFORMATION~

Name _____ Social Security # _____
(Last Name) (First Name) (MI)
Address _____
City _____ State _____ Zip _____
Sex: M F Age _____ Birthdates _____ Single Married Widowed Separated Divorced
Are you Employed? Full-Time Part-Time Are you a student? Full-Time Part-Time
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Whom may we thank for referring you? _____
Name of your primary care physician? _____
How did you hear about us? (yellow pages, web-site, friend, family member, etc.) _____
In case of emergency who should be notified? _____

~PRIMARY INSURANCE~

Person Responsible for Account _____
(Last Name) (First Name) (MI)
Relation to Patient _____ Date of birth _____ SS# _____
Address (If different from patients) _____ Phone _____
City _____ State _____ Zip _____
Responsible Person Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____
Contract# _____ Group# _____ Subscriber# _____
Name(s) of other dependents covered under this plan _____

~ADDITIONAL INSURANCE~

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Relation to Patient _____ Date of birth _____
Address (If different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone _____
Insurance Company _____ Social Security # _____
Contract# _____ Group# _____ Subscriber# _____
Name(s) of other dependents covered under this plan _____

~ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY~

I, the undersigned certify that I (or my dependents) have insurance coverage with _____
(Name of Insurance Company)
and I assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I further authorize the Doctor to release all information required to secure payment of benefits and the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by the insurance company. OSMS will file my insurance as a courtesy; however, it is my responsibility to pay all charges, in full. I will pay, in full, any balances not paid by my insurance company after 90 days. In the event that it is necessary for OSMS to place this account for collection, I agree to pay for any/all collection costs.

(Responsible Party Signature) (Relationship) (Date)