OPTUM Care™
Medical Group

PATIENT REGISTRATION FORM
(please print)

TODAYS DATE:	INSURANCE CARD COPIED: ❒ Yes ❒ No

PATIENT INFORMATION

❒ Mr.	❒ Miss	❒ Ms.	❒ Mrs.	PRIMARY DOCTOR:

PATIENT'S LAST NAME: FIRST: MIDDLE: PREVIOUS LAST: NICKNAME:

SOCIAL SECURITY NO.: - -	DRIVER'S LICENSE NO.:	BIRTH DATE: / /	Sex: ❒ M ❒ F

HOME ADDRESS:	CITY:	STATE:	ZIP CODE:

HOME PHONE NO.: ( )	DAY PHONE NO.: ( )	ALT. PHONE NO.: ( )

CELL PHONE NO.: ( )	EMAIL ADDRESS:

PRIMARY LANGUAGE SPOKEN:

HOW DID YOU HEAR ABOUT US? ❒ Family/Friend ❒ Internet ❒ Website ❒ Insurance

❒ Physician ❒ Community event ❒ Employer event ❒ Brochure/Flyer/Postcard ❒ Other _____

NAME OF REFERRING PROVIDER: PHONE NO.:

MARITAL STATUS: ❒ Single ❒ Widow ❒ Separated ❒ Married ❒ Divorced ❒ Domestic Partner

(REQUIRED BY THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES)

RACE: ❒ American Indian or Alaskan Native ❒ Asian ❒ Black or African American ❒ White
❒ Native Hawaiian or Pacific Islander ❒ Unknown/Not Reported

ETHNICITY: ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Unknown/Not Reported

EMPLOYER:	EMPLOYER PHONE NO.:	EXT.:

EMPLOYER ADDRESS:	CITY:	STATE:	ZIP CODE:

FINANCIALLY RESPONSIBLE PARTY / INSURED SUBSCRIBER ❒ Same as above

(Please provide your insurance card(s) to the receptionist.)

FULL NAME:	SOCIAL SECURITY NO.: - -	BIRTH DATE: / /

HOME ADDRESS (IF DIFFERENT FROM ABOVE):	CITY:	STATE:	ZIP CODE:

HOME PHONE NO.: ( )	CELL PHONE NO.: ( )	RELATIONSHIP TO PATIENT:

EMPLOYER:	EMPLOYER PHONE NO.:	EXT.:

EMPLOYER ADDRESS (IF DIFFERENT FROM ABOVE):	CITY:	STATE:	ZIP CODE:

OPTUM Care™
Medical Group

PATIENT REGISTRATION FORM
(Continued)

INSURANCE INFORMATION			
PATIENT COVERED BY INSURANCE: ❒ Yes ❒ No		❒ CASH PATIENT	
NAME OF PRIMARY INSURANCE:			
SUBSCRIBER'S NAME:	SOCIAL SECURITY NO.: - -	BIRTH DATE: / /	
GROUP NO.:	POLICY NO.:	CO-PAYMENT: $	
PATIENT'S RELATIONSHIP TO SUBSCRIBER: ❒ Self ❒ Spouse ❒ Child ❒ Other			

NAME OF SECONDARY INSURANCE (IF APPLICABLE):			
SUBSCRIBER'S NAME:	SOCIAL SECURITY NO.: - -	BIRTH DATE: / /	
GROUP NO.:	POLICY NO.:	CO-PAYMENT: $	
PATIENT'S RELATIONSHIP TO SUBSCRIBER: ❒ Self ❒ Spouse ❒ Child ❒ Other			

EMERGENCY CONTACT		
(CONTACT NO. 1) FULL NAME:	RELATIONSHIP TO PATIENT:	
HOME PHONE NO.: ( )	CELL PHONE NO.: ( )	ALTERNATE PHONE NO.: ( )
(CONTACT NO. 2) FULL NAME:	RELATIONSHIP TO PATIENT:	
HOME PHONE NO.: ( )	CELL PHONE NO.: ( )	ALTERNATE PHONE NO.: ( )

TREATMENT OF MINOR CONSENT / AUTHORIZATION

I authorize OptumCare Medical Group and/or their associates to render medical or surgical treatment to the above named minor of whom I am the parent or legal guardian.

Signature of parent / legal guardian: _____ **Date:** _____

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT – CONSENT FOR TREATMENT

I, the undersigned, assign all medical or surgical benefits from the insurance carrier(s) listed above directly to OptumCare Medical Group and/or their associates for services rendered to me (or my dependents). I understand that I am financially responsible for all charges whether or not they are paid by my insurance.

I understand that if my insurance has not been paid within 90 days of claims submittal, I will become financially responsible for the charges. I hereby authorize this office to release all information required by the insurance carrier(s) listed above to secure the payment of benefits.

I fully understand this agreement and consent will continue until cancelled by me in writing.

Signature: _____ **Date:** _____