ORTHOPEDIC ASSOCIATES OF LONG ISLAND

PRECISIONCARE

PATIENT REGISTRATION

Name (Last, First, MI) _____ Sex M F

Date of Birth _____ Age _____ SS#_____ Occupation _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Phone _____ Cell _____ E-mail _____ Marital Status _____

Primary Physician Name: _____ Primary Physician Phone: _____

Pharmacy _____ Address _____ Phone _____

Employer _____ Address _____ Phone _____

Spouse/Parent/Guardian Name _____ Phone _____

Parents Employer: Mother _____ Phone _____

Father _____ Phone _____

Race _____ Ethnicity _____ Language _____

Emergency Contact _____ Phone _____

PRIMARY INSURANCE

Insurance Company _____ Phone _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Member ID _____ Group # _____

Person Responsible for Account (Last, First, MI) _____

Relationship to Patient _____ SS# _____ Date of Birth _____

Employer _____ Business Phone _____

Employer Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE

Insurance Company _____ Phone _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Member ID _____ Group # _____

Person Responsible for Account (Last, First, MI) _____

Relationship to Patient _____ SS# _____ Date of Birth _____

Employer _____ Business Phone _____

Employer Address _____ City _____ State _____ Zip _____

FOR MEDICARE PATIENTS: Is this a Medigap plan? (circle one) Yes No

PATIENT SIGNATURE (if minor, parent or guardian) _____ Date_____

For OALI: checked by _____ Date _____