

MOUNTAIN VIEW ORTHOPEDICS

Kosta Zinis, D.O.

REGISTRATION FORM

Today's Date: _____ Primary Care Physician: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ Mr. Miss Mrs. Ms. Marital status:
Social Security no: _____ Single Mar Div Sep Wid

Is this your legal name? Yes No If not, what is your legal name? (Former name): _____ Birth date: _____ Age: _____ Sex: M F

Street address: _____ Cell phone #: _____ Home phone #: _____
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P.O. box: _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____ Employer phone no.: _____
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How did you find out about us? (Please check one box): Dr. Insurance plan Hospital
 Location Internet Family/Friend Yellow Pages Other

Were you injured? Yes No If yes, how? Workman's Comp (on the job) Auto Other

Date of injury: _____ Please describe the nature of the accident: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Birth date: _____ Address (if different): _____ Home phone #: _____
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Cell phone # ()

Occupation: _____ Employer: _____ Employer address: _____ Employer phone no.: _____
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Is patient covered by insurance? Yes No

Please indicate primary insurance Workman's Comp Auto Medicare Medicaid United
 Blue Cross Aetna Cigna Other Policy # _____

Subscriber's (Insured) name: _____ Subscriber's S.S. no.: _____ Birth date: _____ Group #: _____ Co-payment
\$ _____

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group no.: _____ Policy no.: _____

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____ Relationship to patient: _____ Home phone no.: _____ Work phone no.: _____
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Informed consent is hereby given to Mountain View Orthopedics, P.C. to perform such medical and/or surgical procedures which are deemed necessary. I also consent to the release of information to the insurance company and authorize payment of medical benefits directly to Mountain View Orthopedics, P.C. I also understand I and responsible for any unpaid balance.

Patient/Guardian signature

Date