GOLDEN STATE ORTHOPEDICS & SPINE

NEW PATIENT REGISTRATION

SELECT TYPE OF NEW PATIENT REGISTRATION:

☐ Orthopedic Patient
☐ Physical Therapy Patient

DO YOU HAVE AN UPCOMING APPOINTMENT?

☐ Yes - I have a scheduled appointment

_____ _____
DATE TIME

☐ No - I do not have a scheduled appointment

PATIENT INFORMATION

NAME

_____ _____
FIRST NAME LAST NAME

ADDRESS

_____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____ _____ _____
CITY STATE ZIP

CELL PHONE NUMBER

_____

HOME/WORK/OTHER PHONE NUMBER

_____

EMAIL

_____

SEX

☐ Female ☐ Male ☐ Other/Non-Binary

RACE

☐ Asian
☐ Black or African American
☐ Hawaiian or Pacific Islander
☐ White or Caucasian
☐ American Indian or Alaskan Native
☐ Decline to Identify

Patient Name: _____

Date of Birth: _____

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NEW PATIENT REGISTRATION, CONTINUED

ETHNICITY

- ☐ Hispanic or Latin
- ☐ Not Hispanic or Latin
- ☐ Decline to Identify

PREFERRED LANGUAGE

_____

DATE OF BIRTH

_____ _____ _____

DAY MONTH YEAR

SOCIAL SECURITY NUMBER

_____

MARITAL STATUS

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

REFERRING PHYSICIAN

_____

PRIMARY PHYSICIAN

_____

EMPLOYMENT & GUARDIAN INFORMATION

EMPLOYMENT STATUS

- ☐ Employed
- ☐ Retired
- ☐ Student
- ☐ Unemployed

EMPLOYER'S NAME

_____

EMPLOYER'S PHONE NUMBER

_____

JOB TITLE

_____

GOLDEN STATE ORTHOPEDICS & SPINE

NEW PATIENT REGISTRATION, CONTINUED

RESPONSIBLE PARTY

NAME

_____ _____

FIRST NAME LAST NAME

ADDRESS

_____

ADDRESS LINE 1

_____

ADDRESS LINE 2

_____ _____ _____

CITY STATE ZIP

CELL PHONE NUMBER

_____

HOME/WORK/OTHER PHONE NUMBER

_____

EMPLOYER'S NAME

_____

SOCIAL SECURITY NUMBER

_____

DATE OF BIRTH

_____ _____ _____

DAY MONTH YEAR

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME

_____

TYPE OF INSURANCE

- ☐ PPO
- ☐ POS
- ☐ HMO (John Muir Health network)
- ☐ HMO (Other)
- ☐ Medicare
- ☐ Work Comp
- ☐ Self Pay

INSURANCE ID NUMBER

_____

GOLDEN STATE ORTHOPEDICS & SPINE

NEW PATIENT REGISTRATION, CONTINUED

GROUP/POLICY NUMBER

_____

Please copy the front and back of your insurance card and provide with this form.

Golden State Orthopedics & Spine
2625 Shadelands Drive
Walnut Creek, CA 94598

PRIMARY SUBSCRIBER'S NAME

_____ _____
FIRST NAME LAST NAME

RELATIONSHIP OF SUBSCRIBER TO PATIENT

_____

PRIMARY SUBSCRIBER'S EMPLOYER

_____

PRIMARY SUBSCRIBER'S SOCIAL SECURITY NUMBER

_____

PRIMARY SUBSCRIBER'S DATE OF BIRTH

_____ _____ _____
DAY MONTH YEAR

INSURANCE CUSTOMER SERVICE PHONE NUMBER

_____

IS YOUR CONDITION RELATED TO AN INJURY FROM: (CHECK ALL THAT APPLY)

- ☐ Work
- ☐ Auto
- ☐ Private Injury
- ☐ No Injury

EMPLOYER AT TIME OF INJURY

_____