Patient Registration Form

Patient Last Name:	Patient First Name:	
DOB:	Age:	Sex:
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ White ☐ Other ☐ Decline		Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic ☐ Decline
Address:		
City/ State:	Zip:	
Home Phone:	Cell/Work Phone:	
Emergency Contact Person:	Emergency Contact Phone Number:	
Insured's Name: Please upload Insurance card into MyChart.	Relation to patient:	
Insured's Work Phone	Insured's Home Phone	

Local Pharmacy : (List Name/ Location/ City/ Phone)	
Mail Order Pharmacy:	

ASSIGNMENT OF BENEFITS/AUTHORIZATION

I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM FORMS. IN ADDITION, I REQUEST CLAIMS BE SUBMITTED ON MY BEHALF AND PAYMENT FOR SERVICES RENDERED BE DIRECTLY MADE TO ORINDA MEDICAL GROUP.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR AMOUNTS APPLIED TO INSURANCE POLICY DEDUCTIBLES AND CO-PAYMENTS NOT COVERED BY MY INSURANCE COMPANY.

PATIENT/GUARDIAN SIGNATURE:___________________________________ DATE :_____________________