TAHOE FOREST
ORTHOPEDICS &
SPORTS MEDICINE

Exceptional Care Begins Here

10051 Lake Avenue, Suite 3 • Truckee, CA 96161
Main Office: (530) 587-7461 • Fax: (530) 587-1149

Patient Registration Form

Patient's First Name: _____ MI: _____ Last Name: _____

Preferred Name/Nickname: _____

SSN: _____--_____--_____ DOB: _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Email: _____

Physical Address: _____ City: _____

State: _____ Zip Code: _____ Country: _____

Mailing Address: _____

Contact Preference: ❑ Home ❑ Work ❑ Cell

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Insurance Company: _____

Are you the policyholder? ❑ Yes ❑ No Co-Pay: _____

*If you are NOT the policyholder on your primary insurance, please provide the following information:

Policyholder's Name: _____

DOB: _____ SSN: _____--_____--_____ Phone: _____

Mailing Address: _____

Relationship to Patient: _____

Employer's Name: _____ Employer's Phone: _____

Secondary Insurance Company: _____

Are you the policyholder? ❑ Yes ❑ No Co-Pay: _____

*If you are NOT the policyholder on your secondary insurance, please provide the following information:

Policyholder's Name: _____

DOB: _____ SSN: _____--_____--_____ Phone: _____

Mailing Address: _____

Relationship to Patient: _____

Employer's Name: _____ Employer's Phone: _____

Patient Registration Form

Primary Language: _____ Race: _____ Ethnicity: _____

Employed: ❑ Yes ❑ No

Employer's Name: _____ Employer's Phone: _____

Employer's Address: _____

Occupation: _____

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Self-Employed ❑ Retired ❑ Not Employed

❑ Active Military Duty ❑ Student (Full-Time) ❑ Student (Part-Time)

Emergency Contact: _____ Relationship: _____

Phone: _____

Primary Care Physician: _____

Preferred Pharmacy: _____ City: _____

ACKNOWLEDGEMENT, AUTHORITY, AND RELEASE:

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE FOR THE CARE OF THE ABOVE-NAMED PATIENT. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT FOR SUCH SERVICES AND AGREE TO PAY FOR ALL CHARGES AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE TAHOE FOREST HOSPITAL BUSINESS OFFICE. IN THE EVENT OF DELINQUENCY, I AGREE TO PAY TO THE COST OF COLLECTION, FINANCE CHARGES, AND REASONABLE ATTORNEY FEES. IN ADDITION, I AUTHORIZE THIS OFFICE TO RELEASE INFORMATION ABOUT MY TREATMENT AND MEDICAL HISTORY TO INSURANCE COMPANIES, HOSPITALS, SURGERY CENTERS, PHYSICAL THERAPISTS, OR OTHER MEDICAL FACILITIES OR PROVIDERS AS IS NECESSARY TO PROVIDE FOR THE APPROPRIATE TREATMENT CONSENTED TO ABOVE. IN ADDITION, I AGREE TO THE ASSIGNMENT OF ALL INSURANCE BENEFITS TO THIS OFFICE.

PATIENT SIGNATURE: _____

PRINT PATIENT NAME: _____