Welcome

CCOM MEDICAL GROUP

350 South 40th Street
Muskogee, OK 74401-4915
(918) 683-0753
FAX (918) 683-5677

Thank You For Choosing CCOM Medical Group As Your Health Care Provider!

Please complete and sign this registration form. Our office staff will assist you in utilizing medical benefits when all necessary information is completed and signed. Health benefits are a contract between you and your insurance company. When accepting assignment this office is temporarily granting you credit for the portion we expect insurance to pay. All portions due from you are due at the time of service. Thank you.

PATIENT REGISTRATION (NON MVA - NON WC) **Referring Physician:** _____

Patient Name: _____ **Home Phone:** _____
Address: _____ **Work Phone:** _____
City/State/Zip: _____ **Cell Phone:** _____
Social Security: _____ **Gender:** _____ F _____ M
Date of Birth: _____ **Age:** _____
Email Address: _____
Employer: _____ **Marital Status:** ____S ____M ____W ____D ____O
Address: _____ **Spouse Name:** _____
City/State/Zip: _____ **Spouse Phone:** _____
Emergency Contact: **Emergency Phone:**

If the patient is a minor, please complete the following information regarding <u>the Guarantor</u> (person responsible for payment):

Name: _____ **Phone:** _____
Address: _____ **Date of Birth:** _____
City/State/Zip: _____ **Social Security:** _____

Employer: _____ **Employer Phone:** _____
Address: _____ **Employer Fax:** _____
City/State/Zip: _____

Were you involved in an accident? _____ Y _____ N **Injury Date:** _____
Is your injury work related or did it occur on the job? _____ Y _____ N **Injury Date:** _____

Attorney: _____ **Phone:** _____
Firm: _____ **Fax:** _____
Address: _____
City/State/Zip: _____

Prior <u>written</u> authorization required prior to treatment for Motor Vehicle Accicents (MVA) or Worker Compensation (WC) Claims.

1st Insurance: _____ **Phone:** _____
Policy Holder Name: _____ **Relationship:** _____
Date of Birth: _____ **Social Security #:** _____
Group #: _____ **Policy/Claim #:** _____
Employer: _____ **Employer Phone:** _____

2nd Insurance: _____ **Phone:** _____
Policy Holder Name: _____ **Relationship:** _____
Date of Birth: _____ **Social Security #:** _____
Group #: _____ **Policy/Claim #:** _____

I authorize the release of all or part of the patient's medical records, for this period of care, to any person or corporation liable for any part of the physicians charges. Oklahoma State Law (63.O.S. 1-502.2 and 1-502.3) requires that we advise, "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus, and Acquired Immune Deficiency Syndrome (AIDS)." I further permit a copy of this authorization to be used in place of the original and authorize payment for services to be made directly to the physician's office in this assignment of benefits. I understand that I am responsible to pay for all medical services not covered by insurance as per agreements between my physician and the applicable insurance companies.

Patient's/Parent's/Guardian's Signature ***Date***