

# Welcome



**CCOM MEDICAL  
GROUP**

350 South 40<sup>th</sup> 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 (MVA - WC ONLY)

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: _____	Marital Status: _____ S _____ M _____ W _____ D _____ O
Employer: _____	Spouse Name: _____
Address: _____	Spouse Phone: _____
City/State/Zip: _____	Emergency Phone: _____
Emergency Contact: _____	

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

Name: _____	Phone: _____
Address: _____	Date of Birth: _____
City/State/Zip: _____	Social Security: _____
Email Address: _____	
Employer: _____	Employer Phone: _____
Address: _____	Employer Fax: _____
City/State/Zip: _____	

Were you involved in an accident? \_\_\_\_\_ Y \_\_\_\_\_ N

Accident Date: \_\_\_\_\_

Is your injury work related or did it occur on the job? \_\_\_\_\_ Y \_\_\_\_\_ N

Injury Date: \_\_\_\_\_

Attorney: _____
Firm: _____
Address: _____
City/State/Zip: _____

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

*Prior written authorization required prior to treatment for Motor Vehicle Accidents (MVA) or Worker Compensation (WC) Claims.*

Insurance Co Name: _____
Claims Address: _____
Adjuster Name/Phone #: _____
Claim Number: _____

The above information needs to be the actual claim office and not the local agent. Unless we receive written authorization to treat at the time of treatment you will be responsible for payment at the time of service.

*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 physician's 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