

# USC HEALTHCARE REGISTRATION FORM

## PATIENT INFORMATION

|                          |                                    |                      |                   |              |                           |                             |                       |
|--------------------------|------------------------------------|----------------------|-------------------|--------------|---------------------------|-----------------------------|-----------------------|
| Legal Last Name          |                                    | First                | MI                | AKA Name     |                           | Patient MRN-Office Use Only |                       |
| Social Security          |                                    | Sex                  | Birth Date<br>/ / |              | Marital Status<br>S M W D |                             | Drivers License       |
| Residence Street Address |                                    | Apt                  | City              | State        | Zip                       | Country                     |                       |
| Day Phone<br>( )         |                                    | Evening Phone<br>( ) |                   | Pager<br>( ) |                           | Cell Phone<br>( )           |                       |
| Employer's Name          |                                    | Address              |                   | City         | State                     | Zip                         | Country<br>Occupation |
| Race                     | Religious Preference               |                      | Place of Birth    |              | Email                     |                             |                       |
| Referring Physician      | Referring Physician Street Address |                      | Suite             | City         | State                     | Zip                         | Phone                 |

## PERSON TO CONTACT IN CASE OF EMERGENCY

|   |  |           |       |              |                   |                           |
|---|--|-----------|-------|--------------|-------------------|---------------------------|
| Last Name   |  | First     | MI    | Relationship |                   |                           |
| Residence Street                                  |  | Apt       | City  | State        | Home Phone<br>( ) | Business Phone Ext<br>( ) |
| Nearest Relative or<br>Friend not living with You |  | Last Name | First | MI           | Relationship      |                           |
| Residence Street                                  |  | Apt       | City  | State        | Home Phone<br>( ) | Business Phone Ext<br>( ) |

## GUARANTOR (PERSON WHO GUARANTEES FINANCIAL OBLIGATION)

|                  |  |         |      |              |       |                   |                      |                 |
|------------------|--|---------|------|--------------|-------|-------------------|----------------------|-----------------|
| Last Name        |  | First   | MI   | Relationship |       | Social Security   |                      | Driver's Lic No |
| Residence Street |  | Apt     | City | State        | Zip   | Country           | Evening Phone<br>( ) |                 |
| Employer's Name  |  | Address |      | City         | State | Work Phone<br>( ) |                      | Occupation      |

## INSURANCE INFORMATION

|                            |                   |                  |   |   |                           |                                    |  |
|----------------------------|-------------------|------------------|---|---|---------------------------|------------------------------------|--|
| <b>PRIMARY INSURANCE</b>   | Subscriber's Name |                  | Relationship                                | Subscriber's Residence Street (if not the same as patient) Apt City State Zip |                           |                                    |  |
| Subscriber's SSN           |                   | Subscriber's DOB | Employer Name and Address                   |   |                           | Employer's Phone Number Ext<br>( ) |  |
| Insurance Company Name     |                   |                  | Policy, Cert, Badge, Medicare or Medi-Cal # |   | Plan                      | Group No                           |  |
| Insurance Mailing Address  |                   |                  |   |   | Insurance Co Phone<br>( ) |                                    |  |
| Medical Group Name or IPA  |                   |                  | Medical Group Phone Number<br>( )           |   |                           | Effective Date                     |  |
| <b>SECONDARY INSURANCE</b> | Subscriber's Name |                  | Relationship                                | Subscriber's Residence Street (if not the same as patient) Apt City State Zip |                           |                                    |  |
| Subscriber's SSN           |                   | Subscriber's DOB | Employer Name and Address                   |   |                           | Employer's Phone Number Ext<br>( ) |  |
| Insurance Company Name     |                   |                  | Policy, Cert, Badge, Medicare or Medi-Cal # |   | Plan                      | Group No                           |  |
| Insurance Mailing Address  |                   |                  |   |   | Insurance Co Phone<br>( ) |                                    |  |
| Medical Group Name or IPA  |                   |                  | Medical Group Phone Number<br>( )           |   |                           | Effective Date                     |  |

**Assignment of Benefits:** I hereby authorize the doctors of USC Healthcare to furnish information to insurance carriers.  
 I hereby irrevocably assign to the doctors of USC Healthcare all payments for services rendered and all major medical benefits.  
**Consent for Treatment:** I hereby authorize my consent to be treated now and in the future by the doctors of USC Healthcare.

\_\_\_\_\_  
Signature of Patient/Insured

\_\_\_\_\_  
Date

|                        |  |       |  |      |
|------------------------|--|-------|--|------|
| <b>Office Use Only</b> | Documents scanned:   | Name: |  | Ext: |
|                        | <input type="checkbox"/> ID Card <input type="checkbox"/> Ins Card <input type="checkbox"/> Referral |       |  |      |