USC UNIVERSITY HOSPITAL

USC CENTER FOR ORTHOPEDIC SPINAL SURGERY AT USC UNIVERSITY HOSPITAL

1450 SAN PABLO STREET, SUITE 5100 • LOS ANGELES, CA 90033
TELEPHONE 323-442-5300

9209

PATIENT INFORMATION RECORD
(PLEASE PRINT OR WRITE LEGIBLY)

PATIENT INFORMATION

☐ MR. ☐ MRS. ☐ MS. **DATE**

PATIENT NAME	MARITAL STATUS (S / M / W / DIV / SEP)	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY	CITY AND STATE ZIP CODE	HOME PHONE NO. ( )

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE # ( )

EMPLOYER'S STREET ADDRESS	CITY AND STATE - ZIP CODE

IN CASE OF EMERGENCY CONTACT	PHONE NO.	DRIVER'S LIC. NO. OF PATIENT

SPOUSE'S NAME	SOCIAL SECURITY NO.

SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE # ( )

EMPLOYER'S STREET ADDRESS	CITY AND STATE - ZIP CODE

WHO REFERRED YOU TO THIS PRACTICE?

IF THE PATIENT IS A MINOR OR STUDENT

FATHER'S NAME	DOB	STREET ADDRESS CITY, STATE AND ZIP CODE	HOME PHONE # ( )

FATHER'S EMPLOYER	OCCUPATION	SOC. SEC. #	BUSINESS PHONE # ( )

EMPLOYER'S STREET ADDRESS	CITY AND STATE - ZIP CODE

MOTHER'S NAME	DOB	STREET ADDRESS CITY, STATE AND ZIP CODE	HOME PHONE # ( )

MOTHER'S EMPLOYER	OCCUPATION	SOC. SEC. #	BUSINESS PHONE # ( )

EMPLOYER'S STREET ADDRESS	CITY AND STATE - ZIP CODE

If patient is a minor (under the age of 18 years) signature of parent or guardian authorizing treatment:

☐ Guardian ☐ Parent

Relationship _____ Signature _____

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT IF NOT ABOVE	STREET ADDRESS, CITY, STATE AND ZIP CODE	HOME PHONE # ( )

MEDICARE # ☐ PRIMARY ☐ SECONDARY

☐ INSURANCE COMPANY	NAME OF POLICY HOLDER	CERTIFICATE NO./SOCIAL SEC. #	GROUP NO.

ADDRESS, CITY, STATE AND ZIP CODE	PHONE #

INSURANCE COMPANY	NAME OF POLICY HOLDER	CERTIFICATE NO./SOCIAL SEC. #	GROUP NO.

ADDRESS, CITY, STATE AND ZIP CODE	PHONE #

In order to control our cost of billing, we request that initial office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees.

AUTHORIZATION: I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurances.