Corona Temecula Orthopaedic Associates
MEDICAL GROUP INC.

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Corona, CA 92879
(951) 735-6060
www.CTOAMG.com

28078 Baxter Road, Suite 330/340
Murrieta, CA 92563
(951) 677-2157
Fax (951) 735-4510

Provider you will be seeing:

Physician
☐ Baum, Bradley L. ☐ Rouhe, Richard L.
☐ Locke, John S. ☐ Tooma, Ghassan S.
☐ Roghani, Reza

Physician Assistant
☐ Andrew Shaw ☐ Demetrio Quismorio, Jr.
☐ Carl McPherson III ☐ Joseph Robles ☐ Kyle Daniels

PATIENT REGISTRATION FORM

NAME (Last, First, Middle Initial)	SSN#	BIRTHDATE	SEX ☐ *MALE* ☐ *FEMALE*
PRIMARY ADDRESS		EMERGENCY CONTACT NAME	
CITY, STATE, ZIP		BIRTHDATE	Relationship to Patient
EMAIL ADDRESS		PHONE	
PHONE ☐ *HOME* ☐ *CELL* ☐ *OTHER*		PRIMARY CARE PHYSICIAN	
PHONE ☐ *HOME* ☐ *CELL* ☐ *OTHER*		PRIMARY CARE PHYSICIAN PHONE NUMBER	
MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated			

PRIMARY INSURED/RESPONSIBLE PARTY (If different than above)

NAME (Last, First, Middle Initial)	SSN#	BIRTHDATE	SEX ☐ *MALE* ☐ *FEMALE*
PRIMARY ADDRESS		RELATIONSHIP TO PATIENT	
CITY, STATE, ZIP			

PRIMARY INSURANCE

****REQUIRED FIELD**

NAME OF INSURANCE COMPANY**	**POLICY #****	GROUP #
NAME OF PRIMARY INSURED MEMBER**	**DATE OF BIRTH****	**RELATIONSHIP TO PATIENT****
ADDRESS OF INSURANCE COMPANY	**CO-PAY AMT****	DEDUCTIBLE
CITY, STATE, ZIP	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If applicable)

NAME OF INSURANCE COMPANY		**POLICY #**	
ADDRESS OF INSURANCE COMPANY		GROUP #	
CITY, STATE, ZIP		CO-PAY AMT	DEDUCTIBLE
NAME OF PRIMARY INSURED MEMBER	**DATE OF BIRTH**	EFFECTIVE DATE	EXPIRATION DATE

OTHER

RACE: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Latino/Hispanic ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Multiple ☐ White ☐ Refuse to report

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Refuse to report

LANGUAGE: ☐ English ☐ Spanish ☐ Other (Please specify): _____

I hereby assign the insurance benefits to which I am entitled, directly to CORONA-TEMECULA ORTHOPAEDIC ASSOCIATES (CTOA), a medical group. I understand that I am financially responsible for all charges regardless of insurance verification benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. I hereby authorize treatment by CORONA ORTHOPAEDIC ASSOCIATES MEDICAL GROUP, INC. A Photostat of this authorization is accepted with the same authority as original.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

This agreement will remain valid from this day forward to include all future services relating to the above patient, or until changes in the above information are required. It is the patient's responsibility to notify CTOA of any changes in information.