ORNOA

Patient Registration Form
APPOINTMENT REQUEST

Please try to complete as much information as possible, so that we can arrange services for you. Please complete form on line or print and fax to **786-664-3342.**

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: **F** ❑ **M** ❑ DOB:_____ Marital status: Single ❑ Married ❑ Divorce ❑ Widow(er) ❑

Address: _____

City/State/Zip Code: _____ Country: _____

Primary language: _____ Country passport issued at: _____

Telephone (w/country and city code if out of area): _____

Cell number: _____ Work number:_____

Email: _____ Fax number: _____

Contact in case of emergency: _____Relationship: _____ Tel: _____

HEALTH INSURANCE INFORMATION

Do you have insurance that will cover your medical services in the United States?

Yes ❑ **No** , I am self pay ❑

Insurance company name: _____ Policy number: _____

Group: _____ Insurance Telephone number: _____

Insurance address: _____

Patient's relationship to policy holder: Self ❑ **Spouse** ❑ **Child** ❑ **Other:** _____

Name of person responsible for payment: _____

Relationship: _____Telephone: (include area, country, city code):_____

Address: _____ City/State/Zip Code: _____

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Primary diagnosis or clinical problem which brings you to seek medical services?

_____

_____

_____

If known, what physician(s),specialist (s) would you like to see in South Florida? _____

_____

_____

_____

Who is your referring or local physician: _____ Specialty: _____

Local/Referring physician telephone (area, country/city codes): _____

_____

May we contact this physician? **Yes** ❑ **No** ❑

What date would you like your appointment?

1st choice:_____ 2nd choice: _____ 3rd choice: _____

Would you like us to assist you with lodging, transportation arrangements? **Yes** ❑ **No** ❑

Other Servies_____

What location in South Florida will you, or are you staying in? Miami Area ❑ Ft Lauderdale Area ❑

Other location: _____

Are you ambulatory? **Yes** ❑ **No** ❑ List any physical disabilities:_____

How did you hear about ORNOA?

Referred by physician ❑ **Referred by friend/family** ❑ **Internet/Web** ❑

*Please include the following documents with your registration:

❑ ORNOA consent form
❑ Copy of a photo ID (license, passport, etc)
❑ Copy of insurance card (font and back)

Do you have your recent medical records: **Yes** ❑ **No** ❑

Would you like our assistance getting medical records/reports? Yes ❑ Location of records: _____

_____

_____

This registration is not a legal agreement or contract. This registration simply collects general information about a person wishing to receive non emergency care from a medical provider in South Florida. We will use this information to best match the patient's needs with the appropriate specialist, or medical center. Thank you!

Tel: (954)965-7002 • Fax: (786)664-3342 • e-mail: moreinfo@ornoa.com