Dr. Darius E. Lin
22 Odessey Suite 270B
Irvine CA 92618
949-431-2668

PATIENT REGISTRATION

PATIENT INFORMATION				
NAME *Last*	*First*	*MI*	BIRTHDAY	SEX M F
ADDRESS		CITY, STATE		ZIP
HOME PHONE	CELL PHONE		EMAIL	
PREFERRED LANGUAGE	SSN		MARITAL STATUS	
RACE ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ HISPANIC OR LATINO ☐ ASIAN ☐ MIDDLE EASTERN ☐ OTHER_______________			ETHNICITY	

INSURANCE INFORMATION			
PRIMARY INSURANCE COMPANY			POLICY NUMBER
ADDRESS OF INSURANCE COMPANY			GROUP NUMBER
CITY, STATE, ZIP			PHONE NUMBER
NAME OF INSURED	DATE OF BIRTH	SSN	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY			POLICY NUMBER
ADDRESS OF INSURANCE COMPANY			GROUP NUMBER
CITY, STATE, ZIP			PHONE NUMBER
NAME OF INSURED	DATE OF BIRTH	SSN	RELATIONSHIP TO PATIENT

EMERGENCY CONTACT		
NAME	RELATIONSHIP TO PATIENT	
ADDRESS	CITY, STATE	ZIP
CELL PHONE	HOME PHONE	WORK PHONE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Irvine Orthopedics or insurance company to release any information required to process my claims.

______________________________ Ptient/Guardian signature

______________ Date