PATIENT REGISTRATION

Male ☐ Female ☐

Patient Name _____ (last) _____ (first) _____ (middle initial)

Home Address _____ (street) _____ (apt. #) Home Phone (_____) (area code) _____

_____ (City) _____ (State) _____ (Zip)

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/er ☐ Dependant ☐

Birth date_____/____/_____Age_____ Social Security #_____

Primary Care Physician:_____ Referred by Attorney _____

Referred by Dr./patient/friend:_____ _____

Patient's Employer/School: _____ Drivers License # _____

Employment School_____ (street address) Occupation _____

_____ (city) (state) (zip) Phone _____

Parent / Spouse Name _____ Employer _____Phone _____

List any Allergies: _____

List any Current Medications: _____

BILLING INFORMATION

Name of person responsible for bill_____ (relationship) (social security #)

Address (if not as above) _____ (street) (city) (state) (zip)

Home Phone_____ Employer _____

Work Phone _____ Address_____

IN ORDER TO BILL YOUR INSURANCE, WE MUST HAVE A COPY OF YOUR CARD

PRIMARY INSURANCE	ANY OTHER INSURANCE
Ins. Co. Name _____	Ins. Co. Name _____
Subscriber Name _____	Subscriber Name_____
Date of Birth _____	Date of Birth _____
Group # _____ID# _____	Group # _____ ID# _____
Subscriber's Employer_____	

Does Your Insurance Carrier require a referral Yes ☐ No ☐

INJURY INFORMATION

Part of the body Injured _____ L ☐ R ☐ Date of Injury _____

How did the Injury Happen? _____ Employer at time of Accident_____

Where? Home ☐ Auto ☐ Work ☐ Sports ☐ School ☐ Other ☐ Claim Number _____

Name of Local Person not living with you _____ Relationship_____

Address _____ Telephone # _____

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished to me. I authorize any holder of medical information about me to be released to my insurance company to process payment for medical services received. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, and I accept financial responsibility for non-covered services.

_____Signature _____Date

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