

Date \_\_\_\_\_

### PATIENT REGISTRATION

For Internal Use Only

Patient Number \_\_\_\_\_

#### Patient Information

Social Security # \_\_\_\_\_

Mailing Address \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_

Last Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

E-mail \_\_\_\_\_

Marital Status  Married  Single

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Divorced  Widowed

Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

(Check One)  Employed  Retired  Full Time Student

Other \_\_\_\_\_

Referring Physician \_\_\_\_\_

Employer \_\_\_\_\_

How did you hear of us? \_\_\_\_\_

Occupation \_\_\_\_\_

#### Insurance Information

Commercial  Medicaid  Medicare  Worker's Compensation  Other \_\_\_\_\_

Please Provide Your Insurance Card To The Receptionist

Insurance Company \_\_\_\_\_ Accident Date \_\_\_\_\_

Insured / Card Holder's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

#### Secondary Insurance Information

Commercial  Medicaid  Medicare  Worker's Compensation  Other \_\_\_\_\_

Insurance Company \_\_\_\_\_ Accident Date \_\_\_\_\_

Insured / Card Holder's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

#### Workers' Compensation Information

Company Name \_\_\_\_\_ Company Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Supervisor's Name \_\_\_\_\_ Supervisor's Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Date of Injury \_\_\_\_\_

#### Emergency Contact

Social Security # \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Last Name \_\_\_\_\_

Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

#### Spouse / Guarantor / Responsible Party

Social Security # \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relationship \_\_\_\_\_

Daytime ( \_\_\_\_\_ ) \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_

Employer \_\_\_\_\_

Last Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

\_\_\_\_\_  
SIGNATURE (Patient or Parent if Minor)

\_\_\_\_\_  
DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process Insurance claims.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE