

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