Date:_____ **PATIENT REGISTRATION** **For internal use only**
Patient Number_____

Social Security #_____ **Mailing Address_____**

First Name_____MI_____ **Physical Address_____**

Last Name_____ **City_____State_____Zip_____**

Sex____ Age_____ Date of Birth___/___/_____ **E-mail_____**

Marital Status ☐ **Married** ☐ **Single** **Home Phone (___)_____Cell Phone (___)_____**

☐ **Divorced** ☐ **Widowed** **Work Phone (___)_____Other contact (___)_____**

(Check One) ☐**Employed** ☐ **Retired** ☐ **Student**

Employer_____ **Occupation_____**

Consulting Physician_____ **Referring Physician_____**

Emergency Contact Information:
Name:_____Relationship_____Phone(___)_____

Insurance Information: Please Provide Insurance card to Receptionist_____

(Check One) ☐ **Worker's Compensation** ☐ **Commercial** ☐ **Medicare** ☐ **Medicaid** ☐ **Other_____**

Insurance Company:_____Accident Date:_____
Insured/Card Holder's Name:_____Relationship:_____
Policy#_____Group#_____Phone: (____)_____

Secondary Insurance Information:_____

(Check One) ☐ **Worker's Compensation** ☐ **Commercial** ☐ **Medicare** ☐ **Medicaid** ☐ **Other_____**

Insurance Company:_____Accident Date:_____
Insured/Card Holder's Name:_____Relationship:_____
Policy#_____Group#_____Phone: (____)_____

Workers' Compensation Information: DATE OF INJURY_____

Company Name_____ **Company Phone (____)_____**
Supervisor's Name_____ **Supervisor Phone(___)_____**

Spouse/ Guarantor / Responsible Party:

Social Security#_____ **Date of Birth____/____/_____Sex_____**
First Name_____MI_____ **Last Name_____**
Address_____ **Phone Number(____)_____**
City_____State_____Zip_____

Employer_____ **Address_____**
Phone(____)_____ **City_____State_____Zip_____**

I hereby consent to any and all treatment as deemed necessary for my care.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if an, 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 (Patient or Parent if Minor) **Date**

Updated 12-7-18