

PATIENT REGISTRATION FORM

Date _____

PATIENT'S LAST NAME _____ FIRST _____ MIDDLE IN _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

E-MAIL ADDRESS _____ LANGUAGE _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

SEX _____ MALE _____ FEMALE _____ MARITAL STATUS _____ MARRIED _____ SINGLE _____ WIDOW _____ DIVORCED _____

PATIENT SPOUSE'S NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ OCCUPATION _____

PATIENT EMPLOYER _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORKER'S COMPENSATION

W/C INSURANCE COMPANY _____ PHONE _____

COMPANY (PLACE OF INJURY)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CONTACT PERSON _____ CLAIM NUMBER _____

DATE OF INJURY APPROVAL _____

REFERRAL INFORMATION _____ PHYSICIAN _____

ADDRESS _____ PHONE _____

HEALTH PLAN _____ OTHER SOURCE _____

How did you hear about us? _____

Referral? _____ yes _____ no Referring Doctors Name _____ Phone _____

Reason for your visit? _____

Would you like an appointment reminder E-mailed to you? _____ YES _____ NO E-mail address _____

INSURANCE INFORMATION

POLICY HOLDER _____

PRIMARY INSURANCE CARRIER _____ PHONE NUMBER _____

____ HMO ____ PPO ____ PSO ____ MANAGED CARE ____ OTHER DEDUCTIBLE \$ _____ E.R. \$ _____

MEMBER'S NAME _____ EFFECTIVE DATE _____

GROUP NO. _____ SUBSCRIBER ID NO. _____

INSURANCE CARD ADDRESS _____ EFFECTIVE DATE _____

DATE VERIFIED: _____ INTL _____ COVERS: _____ MEMBER _____ SPOUSE _____ DEPEND _____

COVERS OFFICE VISIT: _____ YES _____ NO COVERS HOSPITAL VISIT: _____ YES _____ NO

RELATIONSHIP OF PATIENT TO INSURED _____ HUSBAND _____ WIFE _____ CHILD

CHILD - RESPONSIBLE PARTY; NAME _____ PHONE _____

ADDRESS _____

POLICY HOLDER _____

SECONDARY INSURANCE CARRIER _____ PHONE NUMBER _____

____ HMO ____ PPO ____ PSO ____ MNGD CARE ____ OTHER DEDUCT ABLE \$ _____ E.R. \$ _____

MEMBERS NAME _____ EFFECTIVE DATE _____

GROUP NO. _____ SUBSCRIBER ID NO. _____

INSURANCE CARD ADDRESS _____ EFFECTIVE DATE _____

DATE VERIFIED: _____ INTL _____ COVERS: _____ MEMBER _____ SPOUSE _____ DEPEND _____

COVERS OFFICE VISIT: _____ YES _____ NO COVERS HOSPITAL VISIT: _____ YES _____ NO

RELATIONSHIP OF PATIENT TO INSURED _____ HUSBAND _____ WIFE _____ CHILD

CHILD - RESPONSIBLE PARTY; NAME _____ PHONE _____

ADDRESS _____

We cannot render services on the assumption that our charges will be paid by the insurance company. All services will be charged directly to the insurnace but the patient remains personally responsible for payment. I have reviewed this information and it is accurate to the best of my knowledge.