PATIENT REGISTRATION

Patient Name: _____

Street Address: _____

City/State: _____ Zip Code:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____-____-_____ Date of Birth: _____ Age: _____

Circle One:
Sex: M F Marital Status: Married Single Divorced Widowed

Employment: Full Time Part Time Student- Full Time Student – Part Time

Emergency Contact: _____ Phone #: _____

Is this a work related injury: Yes No If so, date of injury? _____

Employer Name: _____ Phone #: _____

Employer Address: _____

Person responsible for bill: _____ DOB: _____
(If patient is under the age of 18 please list parent or legal guardian information)

Primary Insurance: _____

Policyholder Name: _____ Date of Birth: _____

Subscriber ID#: _____ SSN: _____Group#: _____

Secondary Insurance: _____

Policyholder Name: _____ Date of Birth: _____

Subscriber ID#: _____ Subscriber SSN: _____ Group#: _____

It is our policy to bill your insurance carrier as a courtesy to you, therefore we request your signature below authorizing release of any medical or other information necessary to process your insurance claim and payment of those medical benefits are to be paid directly to this provider of service. By signing this, you or your legal representative acknowledge full responsibility for the payment at the time the service is rendered of any co-pay, deductible, coinsurance or any amount not covered by insurance. Your signature also authorizes consent for treatment and the release of medical records to other attending physicians.

_____ _____

Signature of patient or legal guardian **Date**