

Insurance cards copied
Date: _____

PATIENT REGISTRATION INFORMATION

Account #: _____

Please PRINT and complete ALL sections below!

Is your condition a result of a work injury? Yes No Auto accident? Yes No Other _____

PATIENT'S PERSONAL INFORMATION

Marital status: Single Married Divorced Widowed Sex: M F

Name: _____ Date of injury: _____ State: _____
LAST NAME FIRST NAME INITIAL
Street address: _____ (Apt # _____) City: _____ State: _____ Zip: _____
Home phone: (_____) _____ Work phone: (_____) _____ Social Security # _____-_____-_____
Date of Birth: ____/____/____ Driver's license: (State): _____
Employer/Name of school: _____ Full time Part time
Spouse's name: _____ Work phone: (_____) _____
LAST NAME FIRST NAME INITIAL
How do you wish to be addressed? _____ Spouse's social security # _____-_____-_____

PATIENT/RESPONSIBLE PARTY INFORMATION

Responsible party: _____ Date of Birth: _____
Relationship to Patient: Self Spouse Other _____ Social Security # _____-_____-_____
Responsible party's home phone: (_____) _____ Work phone: (_____) _____
Address: _____ (Apt # _____) City: _____ State: _____ Zip: _____
Employer's Name: _____ Phone number: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____
Your occupation: _____
If patient is a child, other parent's name: _____
Home address: _____
Home phone: (_____) _____ Work phone: (_____) _____ Occupation: _____

PATIENT'S INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST

PRIMARY insurance company's name: _____
Insurance address: _____ City: _____ State: _____ Zip: _____
Name of insured: _____ Date of birth: _____ Relationship to insured: Self Spouse
 Other Child
Insurance ID number: _____ Group number: _____
SECONDARY insurance company's name: _____
Insurance address: _____ City: _____ State: _____ Zip: _____
Name of insured: _____ Date of birth: _____ Relationship to insured: Self Spouse
 Other Child
Insurance ID number: _____ Group number: _____
Check if appropriate: Medigap policy Retiree coverage

PATIENT'S REFERRAL INFORMATION

Referred by: _____ Address: _____
Reason for consultation: _____

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone number (home): (_____) _____ Phone number (work): (_____) _____

ASSIGNMENT OF BENEFITS — FINANCIAL AGREEMENT

ASSIGNMENT AND RELEASE: I authorize payment of benefits be made directly to this healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

Signed: _____

Method of payment:

Cash Check Credit card

Your Signature: _____ Date: _____