

Insurance cards copied

PATIENT REGISTRATION INFORMATION

Account #: _____

Date: _____

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: (_____) _____ Cell phone: (_____) _____ Social Security # _____

Date of Birth: ____/____/____ Driver's license: (State): _____ Email: _____

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: _____