PATIENT REGISTRATION

Today's Date: _____

PATIENT INFORMATION:

Name: _____ Birth date: _____

SS#:_____ Age: _____ Sex: M or F Marital Status M S W D Other

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Employer_____ Occupation _____Employment Status: F/T P/T Not Employed

Emergency Contact #1:_____ Relationship: _____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

Emergency Contact #2:_____ Relationship: _____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

Primary Care Physician: _____ Phone: ( ) _____How did you hear about us? _____

PERSON RESPONSIBLE FOR BILL (self is over 18, legal guardian if under age 18):

Name: _____ Birth date: _____

SS#:_____ Age: _____ Sex: M or F Marital Status M S W D Other

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Employer_____ Occupation _____Employment Status: F/T P/T Not Employed

Relationship to Patient (only if different) _____

PRIMARY INSURANCE (please present card for verification):

Insurance Name: _____ Copay Amount-PCP $_____Specialty_____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber Name_____ Sex: M or F Birth date_____

Subscriber's Address_____ Work Phone ( ) _____

Insurance ID#:_____ Group #: _____ Effective date: _____

SS#:_____ Relationship to patient: _____

Employer: _____Occupation: _____ Employment Status: F/T P/T Not Employed

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SECONDARY INSURANCE

Insurance Name: _____ Copay Amount-PCP $_____Specialty_____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber Name_____ Sex: M or F Birth date_____

Subscriber's Address_____ Work Phone ( ) _____

Insurance ID#:_____ Group #: _____ Effective date: _____

SS#:_____ Relationship to patient: _____

Employer: _____Occupation: _____ Employment Status: F/T P/T Not Employed

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WORKER'S COMPENSATION/AUTO

Is Claim Worker's Compensation? Yes_____ No_____ If yes, Date of Injury_____

If yes, Worker's Compensation Claim Number_____

Worker's Compensation Carrie_____

Contact Person with Carrier_____

Worker's Compensation Insurance mailing address: _____

Is Claim due to a motor vehicle accident: Yes_____ No _____ If yes, Date of injury _____

If yes, motor vehicle claim number: _____

Insured_____ Policy Number _____

Motor Vehicle Carrier_____

Contact Person with Carrier_____

Insurance Mailing Address_____