Patient Registration

Patient Information

Name: _____ Birthdate: ____/____/____ Age: _____

SS#: ____/____/____ Sex: **M** or **F** Marital Status: **M S W D O**ther Email Address: _____

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

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

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____-_____-_____

Primary Care Physician: _____ Phone: _____-_____-_____

Referring Physician: _____ Phone: _____-_____-_____

Primary Insurance

Insurance Name: _____ CoPay Amount **PCP**: $_____ **Specialty**: $_____

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

Subscriber's Name: _____ SS#:_____/_____/_____ Sex: **M** or **F** Birthdate: ____/____/____
(If different from above)

Subscriber's Address: _____ City: _____ State: _____ Zip: _____

Insurance ID #:_____ Group #:_____ Effective Date: ____/____/____
(If applicable)

Relationship to Patient: _____ Employer: _____

Secondary Insurance

Insurance Name: _____ CoPay Amount **PCP**: $_____ **Specialty**: $_____

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

Subscriber's Name: _____ SS#:_____/_____/_____ Sex: **M** or **F** Birthdate: ____/____/____
(If different from above)

Subscriber's Address: _____ City: _____ State: _____ Zip: _____

Insurance ID #:_____ Group #:_____ Effective Date: ____/____/____
(If applicable)

Relationship to Patient: _____ Employer: _____

Patient Registration

Person Responsible for Bill (SELF if over 18)

Name: _____ Birthdate: ____/____/____ Age: _____

SS#: ____/____/____ Sex: **M** or **F** Marital Status: **M S W D O**ther Email Address: _____

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

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

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____-_____-_____

Primary Care Physician: _____ Phone: _____-_____-_____

Referring Physician: _____ Phone: _____-_____-_____

Auto/ Worker's Compensation Type of Claim: **AUTO** or **W/C**

Insurance Name: _____ Phone: _____-_____-_____

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

Contact/ Agent's Name: _____ Phone: _____-_____-_____

Responsible Employer: _____ Phone: _____-_____-_____
(Worker's Comp Only)

Date of Injury/ Accident: ____/____/____ State of Accident: _____ Claim #: _____
(Auto Only)

Describe Injury/ Accident: _____

Patients under 18

Mother/ Guardian's Name: _____ Birthdate: ____/____/____ Age: _____

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

Father/ Guardian's Name: _____ Birthdate: ____/____/____ Age: _____

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