PATIENT REGISTRATION

Today's Date ____/____/_____

PATIENT INFORMATION

Please Provide Your PHOTO ID to Receptionist

First Name______________________________ MI_______ Local Address ____________________________________Apt._________

Last Name____ City ______________________________________ST______Zip_________

DOB_____/______/______ Local Phone (_____) __________________________________

Age _______ Sex: ☐ M ☐ F Work Phone (_____) __________________________________

Marital Status: ☐ Married ☐ Single Employer____

☐ Divorced ☐ Widowed Employer Address____

(Check ONE) ☐ Employed ☐ Retired ☐ Student Primary Physician ____

E-Mail ____ Referring Physician ____

GUARANTOR / RESPONSIBLE PARTY

(**PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT**)

Name ____ Phone (______) _________________________

Last first middle

DOB____/_____/_____ Sex: ☐ M ☐ F E-Mail ____Relationship to patient___________

Address ____

Street City State Zip

Employer ____

Name Address Phone

EMERGENCY CONTACT INFORMATION

Contact Name____ Relationship _________________ Phone Number (_____) ______________

PRIMARY INSURANCE INFORMATION

*Please Provide Your **INSURANCE CARDS** to Receptionist*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other_____________________________________

Insurance Company____Insurance Phone _______________________

Primary Subscriber:____ Relationship to patient ___________________________

Subscriber Address ____Phone (____) __________________

Subscriber Employer ____ Employer Phone _______________________________

ID #:______________________________________ Group #___________________________ **Subscriber's - DOB**______/______/______

SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other_____________________________________

Insurance Company____Insurance Phone _______________________

Primary Subscriber:____ Relationship to patient ___________________________

Subscriber Address ____Phone (____) __________________

Subscriber Employer ____ Employer Phone _______________________________

ID #:______________________________________ Group #___________________________ **Subscriber's - DOB**_____/______/______

AUTO/WORKER'S COMPENSATION INFORMATION

TYPE OF ACCIDENT: ☐ Auto ☐ Work ☐ Other (specify) __________________________________Injury Date____/_____/____

Company Name ____Company Phone (______) ___________________

Claim/Case Number__________________ Claim/Case Manager____________________________________ Phone (_____) ___________

SSN: __________ -- ______ -- ___________