

# PATIENT REGISTRATION

## PATIENT INFORMATION

<b>Patient Name: LAST</b>		<b>FIRST</b>	<b>M.I.</b>	<input type="checkbox"/> <b>M</b> <input type="checkbox"/> <b>F</b>
<b>Preferred Name:</b>		<input type="checkbox"/> <b>Single</b>	<input type="checkbox"/> <b>Married</b>	<input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Other</b>
<b>Patient's Address:</b>				
<b>City</b>		<b>State</b>	<b>Zip</b>	
<b>Home Phone:</b>		<b>Work Phone:</b>	<b>Email:</b>	
<b>Social Security #:</b>		<b>Birthdate:</b>		<b>Age:</b>
<b>Employer:</b>			<b>Occupation:</b>	
<b>Emergency Contact:</b>			<b>Phone #:</b>	
<b>May we contact you via email?</b> <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>				

## Insurance

<b>Name of Insured (if other than self)</b>		<b>SSN:</b>	<b>Birth Date:</b>
<b>Name of Insured's Employer:</b>		<b>Insured's work phone #:</b>	
<b>Patient is:</b> <input type="checkbox"/> <b>Subscriber</b> <input type="checkbox"/> <b>Spouse</b> <input type="checkbox"/> <b>Dependent</b>			
<p>We are required to have a copy of your insurance card(s) on file in order to bill your insurance for you. If we do not have this information on file, you will be billed directly and are solely responsible for all charges. Payment is due at the time of service. If you submit your insurance card at a later date we will bill your insurance company and reimburse you once payment is received.</p>			

## INJURY

<b>Date of Injury:</b>		<b>Type of Injury:</b> <input type="checkbox"/> <b>Work</b> <input type="checkbox"/> <b>Auto</b> <input type="checkbox"/> <b>Other</b>		
<b>Claim Filed:</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b>		<b>Claim #:</b>	<b>Where was claim filed?</b>	
<b>Brief Description of Injury:</b>				

## Referral

<b>Please tell us how you found us:</b>				
<input type="checkbox"/> <b>Friend:</b> _____		<input type="checkbox"/> <b>Web</b> <input type="checkbox"/> <b>Yellow Pages</b>		
<input type="checkbox"/> <b>Other:</b> _____		<input type="checkbox"/> <b>Doctor's Office:</b> _____		
<b>Primary Care Physician:</b>			<b>Phone #:</b>	

## Signature

<b><u>Benefits Release:</u></b>	
<p>I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors office will bill my insurance as a courtesy and that I am responsible for all co-payments and non-covered services. I also understand that it is not he doctors office responsibility to inform me if the services provided are covered by my insurance. I authorize the release of information required to process my claims. If I choose not sign then I understand that payment is due at time of service.</p>	
<b>Patient Signature:</b> _____	<b>Date:</b> _____