OFFICE USE ONLY
P.T. _____
B.D. _____

# PATIENT REGISTRATION

## PERSONAL

TODAY's DATE

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE CELL:
( ) HOME:

MARITAL STATUS
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

DATE OF BIRTH SOCIAL SECURITY # :

WHO REFERRED YOU TO US E MAIL:

## INSURANCE

YOUR PRIMARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS PHONE

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

ASSIGNMENT AND RELEASE: _____

I AGREE THAT DR. DOUGLAS GATES HAS THE AUTHORITY TO SUBMIT BILLINGS FOR SERVICES PROVIDED TO ME. I FURTHER AGREE TO HAVE PAYMENTS SENT DIRECTLY TO HIM. MY SIGNATURE HERE WILL REMAIN ON FILE FOR SUCH PURPOSES.

DISCLOSURE TO THE ABOVE INSURANCE COMPANY IS AUTHORIZED BY ME ALLOWING DR. GATES TO PROVIDE PERSONAL/TREATMENT INFORMATION TO THE INSURANCE COMPANY WHEN NECESSARY TO DETERMINE THE BENEFITS BAND PAAYMENTS FOR SERVICES.


**DR. STEPHANIE GATES**
217 OLD HOOK ROAD, SUITE 3E
WESTWOOD, NJ 07675

TEL. (201) 666-4466
FAX (201) 666-4948


## PLEASE PROVIDE AS MUCH INFORMATION AS YOU CAN... IT MAY HELP US

### THE PROBLEM

DESCRIBE YOUR CONDITION

DESCRIBE HOW AND WHEN IT BEGAN

WHAT TREATMENTS HAVE YOU TRIED FOR THIS PROBLEM

### ADDITIONAL INFORMATION

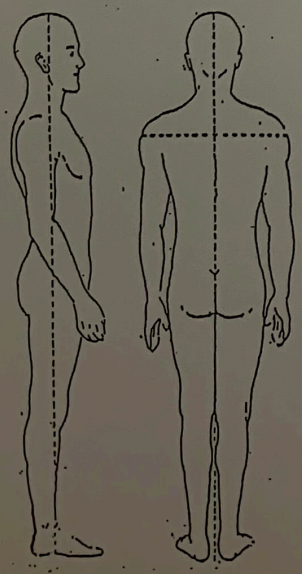
PRIOR ACCIDENTS AND INJURIES

CURRENT MEDICATIONS YOU ARE TAKING

CURRENT VITAMINS YOU ARE TAKING

WHAT IS YOUR OCCUPATION/JOB

ARE YOU ACTIVE IN SPORTS/EXERCISE ROUTINE



EXAM/CONSULTATION $ _____

X-RAYS: $ _____

(CT-2) [ ]
(LS-2) [ ]

TOTAL: $ _____