PATIENT REGISTRATION

PATIENT INFORMATION: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. / ❑ Male ❑ Female / ❑ Married ❑ Single ❑ Widowed

Social Security #: ____________-_________-___________ Birthdate: ___________/____________/_____________ Age: _________

Patient Name: ____
LEGAL FIRST NAME MI LAST

Home Address: ____
No. & STREET APT. No. CITY STATE ZIP

Home Phone: ( ) __________________________________ Cell Phone: ( ) __________________________________

Work Phone: ( ) ___________________ Ext: _________ Employer/Occupation: ______________________________________

Was this due to an accident? ❑ YES ❑ NO Was this work-related? ❑ YES ❑ NO

EMPLOYER CONTACT PERSON: __________________________________ Phone #: ( ) ___________________________

EMERGENCY CONTACT: **Name/phone # of relative(s) and/or friend in case of emergency or appointment changes.**

Name: __________________________________ Phone: ( ) _____________________ Relation: ______________________

SPOUSE'S INFORMATION:

Name: ____ Social Security #: _____________-_________-_____________

Cell Phone: ( ) ____________________________________ Birthdate: _____________/______________/_______________

Work Phone: ( ) _______________________________ Ext: ___________ Employer: _______________________________

MEDICAL INSURANCE INFORMATION: **(Please provide us with information regarding your medical insurance coverage. We also need to make a copy of your most recent insurance card to keep on file)**

1. Primary Insurance Name: _______________________________ Phone#: ( ) __________________________________

ID or Policy #: ____ Group #: ______________________ Co-Pay: $__________

Address: ____

Referral Needed? ❑ YES ❑ NO Name of Primary Insured (if other than self): ____

2. Secondary Insurance Name: _____________________________ Phone#: ( ) _________________________________

ID or Policy #: ____ Group #: _____________________ Co-Pay: $__________

Address: ____

Assignement of Benefits: I hereby authorize the verification of my medical benefits and payments directly to the treating physician. I understand that I am responsible for any portion of my bill not covered by my insurance company.

Release of Information: I hereby authorize the treating physician to release any information required in the course of my treatment to my insurance company.

Authorization of Medical Treatment: I hereby consent and authorize the Physician and any associates of his/her choice to provide medical treatment for the above patient.

Patient Signature: ____ **Date:** __________/___________/___________

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