PATIENT REGISTRATION FORM

WORKERS COMP ☐ **Y** ☐ **N**

Date_____ Home Phone_____ Cell Phone_____

PATIENT INFORMATION

Name_____ SS/HIC/Patient ID#_____

Address_____ E-mail_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for_____years

Race: ☐ African American ☐ White ☐ Hispanic ☐ Asian ☐ Other _____

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Employer/School Phone (_____)_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone (_____)_____

PRIMARY INSURANCE

Person Responsible for Account_____

Last Name First Name Middle Initial

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____

Address (if different from patient's)_____ Phone (_____)_____

City_____ State_____ Zip_____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone (_____)_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents covered under this plan_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____ Birthdate_____ Relation to Patient_____

Address (if different from patient's)_____ Phone (_____)_____

City_____ State_____ Zip_____

Subscriber Employ by_____ Business Phone ( )_____

Insurance Company_____ Soc. Sec. #_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to

Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship of Patient