PATIENT REGISTRATION

(Please Print)

OFFICE USE ONLY

Date: _____

Dx: _____

ICD9 Code: _____

Sched. Serv. Date: _____

PATIENT INFORMATION

NAME (LAST, FIRST, MI) _____ **DATE** _____

ADDRESS _____ HOME PHONE _____

CITY, STATE, ZIP _____ WORK PHONE _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED CELL PHONE _____

SEX: ☐ MALE ☐ FEMALE SOC. SEC. # _____ BIRTHDATE _____ AGE _____

REFERRED TO THIS OFFICE BY _____ PRIMARY CARE PHYSICIAN _____

PATIENT'S EMPLOYER _____ SPOUSE'S/PARENT'S NAME _____

ADDRESS _____ HOME PHONE _____

CITY, STATE, ZIP _____ SPOUSE'S EMPLOYER _____

OCCUPATION _____ OCCUPATION _____ WORK PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH _____

GROUP # _____ ID # _____

INS. ADDRESS _____

INS. PHONE _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER:

☐ SELF ☐ SPOUSE ☐ CHILD ☐ DEPENDENT

SUBSCRIBER'S

EMPLOYER _____

SOCIAL SECURITY _____

IF YOUR PRIMARY INSURANCE IS AN HMO OR PPO, DO YOU HAVE A REFERRAL FORM?

☐ YES ☐ NO

SECONDARY INSURANCE _____

SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH _____

GROUP # _____ ID # _____

INS. ADDRESS _____

INS. PHONE _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER:

☐ SELF ☐ SPOUSE ☐ CHILD ☐ DEPENDENT

ACCOUNT RESPONSIBILITY

NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY # _____

INJURY INFORMATION

ID INJURED: DATE _____ PLACE: ☐ HOME OR SCHOOL ☐ WORK WORK CLAIM # _____

NATURE OR CAUSE OF INJURY: _____ ☐ AUTO ACCIDENT AUTO CLAIM # _____

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, LOCAL FRIEND OR RELATIVE TO BE NOTIFIED (NOT LIVING AT SAME ADDRESS).

NAME _____ HOME PHONE _____

RELATIONSHIP TO PATIENT _____ WORK PHONE _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the healthcare provider as well as release of any information by provider or insurance company required for this account. Release of information to include: (1) alcohol and / or drug abuse treatment, (2) psychiatric diagnosis, treatment and summaries, (3) test results for HIV (Human Immunodeficiency Virus), STD (Sexually Transmitted Diseases), and (4) Treatment of HIV, STDs, AIDS (Acquired Immunodeficiency Syndrome) and related conditions.
Payment: I am financially responsible for any balance due. I agree to make payment arrangements; pay $5 or 1% interest per month (whichever is greater) on unpaid balances over 30 days and all the reasonable expenses such as attorney fees and court costs should account be referred for collections.

SIGNED: X _____