Insurance cards copied ☐
Date: _____

PATIENT REGISTRATION INFORMATION

Account #: _____

Please PRINT and complete ALL sections below!

Is your condition a result of a work injury? ☐ Yes ☐ No Auto accident? ☐ Yes ☐ No Other _____

PATIENT'S PERSONAL INFORMATION

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ M ☐ F

Name: _____ (LAST NAME) _____ (FIRST NAME) _____ (INITIAL) Date of injury: _____ State: _____

Street address: _____ (Apt #_____) City: _____ State: _____ Zip: _____

Home phone: (_____) _____ Work phone: (_____) _____ Social Security #_____–_____–_____

Date of Birth: _____/_____/_____ Driver's license: (State): _____

Employer/Name of school: _____ ☐ Full time ☐ Part time

Spouse's name: _____ (LAST NAME) _____ (FIRST NAME) _____ (INITIAL) Work phone: (_____) _____

How do you wish to be addressed? _____ Spouse's social security #_____–_____–_____

PATIENT/RESPONSIBLE PARTY INFORMATION

Responsible party: _____ Date of Birth: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other _____ Social Security #_____–_____–_____

Responsible party's home phone: (_____) _____ Work phone: (_____) _____

Address: _____ (Apt #_____) City: _____ State: _____ Zip: _____

Employer's Name: _____ Phone number: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Your occupation: _____

If patient is a child, other parent's name: _____

Home address: _____

Home phone: (_____) _____ Work phone: (_____) _____ Occupation: _____

PATIENT'S INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST

PRIMARY insurance company's name: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Name of insured: _____ Date of birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Other ☐ Child

Insurance ID number: _____ Group number: _____

SECONDARY insurance company's name: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Name of insured: _____ Date of birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Other ☐ Child

Insurance ID number: _____ Group number: _____

Check if appropriate: ☐ Medigap policy ☐ Retiree coverage

PATIENT'S REFERRAL INFORMATION

Referred by: _____ Address: _____

Reason for consultation: _____

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number (home): (_____) _____ Phone number (work): (_____) _____

ASSIGNMENT OF BENEFITS — FINANCIAL AGREEMENT

ASSIGNMENT AND RELEASE: I authorize payment of benefits be made directly to this healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

Signed:

Method of payment:

☐ Cash ☐ Check ☐ Credit card Your Signature: _____ Date: _____

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