

Patient Registration Form

PATIENT INFORMATION

DATE: _____

NAME: _____
First Middle Initial Last

ADDRESS: _____
Street/Box/Apt. City State Zip

PHONE: home _____ work _____

Employer: _____ Social Security # _____

Age: _____ Date of Birth: _____ Occupation _____

Sex: Male Female Marital Status: Single Married Separated Divorced Widowed

Spouse's name (parent's name, if child) _____ Day Phone: _____

Emergency Contact: Name: _____

Relationship: _____ Phone: _____

Referring Doctor: _____ Address and/or Phone _____

INSURANCE INFORMATION

Primary Insurance _____
ID# Group Plan

Name of insured _____ Insured's SSN: _____

Secondary Insurance _____
ID# Group Plan

Name of insured _____ Insured's SSN: _____

Does your insurance require pre-authorization, certification, or second opinion? Yes No

If yes, please provide the phone number for contact: _____

Medicare # (if applicable) _____ Medicaid # (if applicable) _____

ACCIDENT INFORMATION

Is this visit because of an accident? Yes No If yes, please give date of accident: _____

If auto accident: Insurance Co. Name, Address, Claim #, Adjuster, Phone #: _____

If happened on the job, please give the following information: Worker's Compensation Insurance Name, Address, Claim #, Adjuster, Phone: _____

RELEASE OF INFORMATION/ PAYMENT AUTHORIZATION

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature

Date