Patient Registration Form

Date _____

Patient Information: Name _____ Age _____

SSN# _____ D.O.B. _____ Sex (circle one) M F Marital Status _____

Address _____ City, State, Zip _____

Home Phone _____ Employer _____ Work Phone _____

Employer's Address _____

Referring Physician _____

How Did Injury Occur _____

Date of Injury _____

Responsible Party Name _____

Relation to Patient ☐ Spouse ☐ Parent ☐ Guardian

Address _____ Home Phone _____

Employer _____ Cell Phone _____

Employer's Address _____ Work Phone _____

D.O.B. _____ SSN# _____

Primary Insurance Name _____

Address _____ City, State, Zip _____

Policy # _____ Group # _____

Policy Holder Name _____

D.O.B. _____ SSN# _____

Employer _____ Work Phone _____

Employer's Address _____

Secondary Insurance Name _____

Address _____ City, State, Zip _____

Policy # _____ Group # _____

Policy Holder Name _____

D.O.B. _____ SSN# _____

Employer _____ Work Phone _____

Employer's Address _____

Authorized signature is on file. By signing, I attest that all information provided is true and complete and that my injury/illness is not work related. I authorize the release of any necessary medical information and Payment of medical benefits to the physician for services rendered. I understand and agree that: 1) I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the Notice; 2) I am fully responsible for all charges to me including the balance remaining after payment of insurance benefits (as per your insurance contract); 3) the responsible party is billed for appointments unkept or cancelled with less than 24 hours notice; 4) a $25 fee will be charges on each returned check; 5) payment is expected on the day services are rendered unless prior arrangements are made; and 6) that the information in this paragraph may not be altered or amended by me.

****All co-pays are due at time of service.**

Patient or Responsible Party Signature: _____

Date: _____