PATIENT REGISTRATION FORM

PLEASE PRINT & BRING WITH YOU

DATE: _____________________

PATIENT INFORMATION

PATIENT LAST NAME FIRST MIDDLE ☐ MR ☐ MRS

☐ MISS ☐ MS

DATE OF BIRTH _____/_____/_____ SEX Male - Female SOCIAL SECURTIY MARITAL STATUS Single/Mar/Div/Sep/Wid

STREET ADDRESS CITY, STATE & ZIP HOME & CELL NUMBER

EMPLOYER EMPLOYER ADDRESS EMPLOYER PHONE NO.

OTHER FAMILY MEMBERS SEEN HERE? ☐ NO ☐ YES NAME______________________________

INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD TO RECEPTIONIST)

IS THE PATIENT COVERED BY INSURANCE? ☐ YES ☐ NO

SUBSCRIBER NAME ______________________________________ DATE OF BIRTH _____/_____/_____

SUBSCRIBER ID # ______________________________________ GROUP # ____________________

INSURANCE CO __________________________ RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTH

IS THIS A JOB RELATED INJURY? ☐ YES ☐ NO IF YES, DATE OF INJURY_____/_____/_____
CLAIM NO. _____________ PLACE OF INJURY: ☐ WORK ☐ MVA ☐ OTHER _______________________

IS PATIENT COVERED BY SECONDARY INSURANCE? PATIENT'S RELATIONSHIP TO SUBSCRIBER

INSURANCE NAME _______________________________ ☐ SELF ☐ SPOUSE

SUBSCRIBER NAME _______________________________ ☐ CHILD ☐ OTHER

ID # _________________________GROUP# ____________________ DATE OF BIRTH _____/_____/_____

CONTACT IN CASE OF EMERGENCY (LOCAL FRIEND OR RELATIVE)

NAME _______________________________________ TELEPHONE NO. _________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to [*Please insert your company name here*]. I understand that I am financially responsible for any balance due from me. I also authorize [*Please insert your company name here*] to release any information required to process my claims.

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PATIENT SIGNATURE DATE
(Guardian's signature if patient is a minor)