PATIENT REGISTRATION

Patient Name: _____ Sex: Male ☐ Female ☐
Last First M.I.

Date of Birth: _____ Social Security #: _____ Ethnicity: _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

Street Address: _____

Marital Status: S☐ M ☐ W ☐ D ☐ Spouse Name: _____ Phone #: _____

REFERRED BY: _____ PCP: _____ PCP #: _____

Reason for Office Visit (Type of Injury/Problem/Illness): _____

Is Patient Currently Employed? Y ☐ N ☐ Financial Responsibility: Self ☐ Other ☐

Patient's Employer: _____ Address: _____

Occupation: _____ Work Phone #: _____

INSURANCE DETAILS

Primary Insurance: _____ Insurance ID#: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SS#: _____ Relationship to Subscriber: _____

Secondary Insurance: _____ Insurance ID#: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SS#: _____ Relationship to Subscriber: _____

Is this a Work Comp. Injury/Claim? Y ☐ N ☐ Insurance Name: _____ Phone: _____

IN CASE OF EMERGENCY

Name: _____ Phone #: _____ Relationship: _____

Address: _____
Street City State Zip

Authorization for Treatment and Financial Agreement: I do hereby consent to medical care encompassing such diagnostic procedures and medical treatment performed on me or ordered by my physician, his assistants, as is necessary in the judgement of my physician. I hereby authorize direct payment to physician of all medical insurance benefits (including without limitations Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by Provider of services to the Patient. I understand that I am financially responsible for charges not covered by insurance benefit and guarantee payment for such charges.

Signature: _____ Date: _____

Patient ☐ Parent or Guardian of Minor ☐ Authorized Representative ☐