# PATIENT REGISTRATION

Patient Name: ____________________________ Sex: Male___ Female__ _

Last First M.I

Date of Birth: _________ Social Security# ________ Ethnicity: _____________ _

Home Phone# ________ Cell Phone# _________ Email: ______________ _

Street Address: _____________________________________ _

Street Apt# City State Zip

Martial 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# __________________ _

Subcriber Name: ___________ _ Subscriber DOB: ________________ _

Subscriber SS# ___________ _ Relationship to Subscriber: ____________ _

Secondary Insurance: _________ _ Insurance ID# ___________________ _

Subscriber Name: __________ _ Subscriber DOB: _________________ _

Subcriber 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 Finanacial 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 by insurance benefit and guarantee payment for such charges.

Signature _____________________ Date ____________ _

Patient ___ Parent or Guardian of Minor ____ Authorized Representative ___ _