



PATIENT REGISTRATION FORM

(Please complete both sides)

PATIENT INFORMATION

Patient Name _____ Date: _____
Last First Middle
 Date of Birth _____ Age _____ Gender F M Social Security # _____
 Address _____
Street City State Zip
 E-mail address _____
 Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____
 Marital Status: Single Married Widowed Divorced Separated Child
If patient is a minor, lives with _____ Relationship _____
 Employed Occupation _____ Retired Full time Student Part time Student
 Employer _____ Phone (____) _____

SPOUSE INFORMATION

Spouse's Name _____ Social Security _____ Birth Date _____
 Spouse's Employer _____ Phone (____) _____

RESPONSIBLE PARTY: IF OTHER THAN PATIENT

Name _____ Relationship to Patient _____
 Address (if other than above) _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Responsible Party's Birthday _____ Social Security # _____
 Employer _____ Address _____

Emergency Contact: Nearest Friend/ Relative Not Living With You

Name _____ Relationship to Patient _____
 Address (if other than above) _____ Phone _____

PRIMARY

INSURANCE INFORMATION

SECONDARY

Company Name _____	Company Name _____
Subscriber's Name _____	Subscriber's Name _____
Subscriber's date of birth _____	Subscriber's date of birth _____
Subscriber's SS# _____	Subscriber's SS# _____
Policy ID# _____	Policy ID# _____



PATIENT REGISTRATION FORM

(Complete the back side)

If Your Treatment is for an injury or accident

Were you injured at Work? ___ yes ___ no Is this covered by Workman’s Compensation? ___ yes ___ no

If Yes, Contact person at your Employer _____

Date & Time of Accident _____ Place of Accident _____

How did the injury happen? _____

Name of Physician who treated you at the time of accident _____

Financial Responsibility / Release of Information Authorization

I herby give consent to the attending physician to release any medical information necessary to my insurance company and the payment of benefits to the Physician for services received. I also authorize the release of information to listed physician and/or individuals. I understand that this consent remains valid unless/until I revoke it myself.

Patient Signature _____ Date _____
Or Legal Guardian

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist in the responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my insurance company and physician, HMO, or other managed entity. If for any reason the account should become delinquent, I am liable to pay for collection and attorney fees.

Patient Signature _____ Date _____
Or Legal Guardian