



Patient Registration

OFFICE USE ONLY

Preferred Pharmacy:

<input type="checkbox"/>	New Patient
<input type="checkbox"/>	Current Patient UPDATE
<input type="checkbox"/>	Workers' Compensation

Patient Name Last First Initial				Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W				Sex <input type="checkbox"/> M <input type="checkbox"/> F			
Home Address			City		State		Zip		Home Telephone		
Employer/School			Employer/School Address				Work Telephone				
Cell Phone		Occupation		Social Security Number		Driver's License No.		State		Birth Date / /	Age
Spouse or Parent Name			Employer's Address				Work Telephone				
Name of Financially Responsible Person (if Different from Patient)										<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Address (if Different from Patient)						Home Telephone		Work Telephone			
Primary Health Insurance Co. Name				Policy Holder			Policy Holder's Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other			Policy Holder DOB / /	
Insurance Co. Address			ID/Policy No.		Group No.		Coverage Code		Effective Date / /		
Secondary Health Insurance Co. Name				Policy Holder			Policy Holder's Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other			Policy Holder DOB / /	
Insurance Co. Address			ID/Policy No.		Group No.		Coverage Code		Effective Date / /		
Family Physician		Referred By		Address			Reference No.	Telephone			
Any Member of Family Treated by Our Group Before <input type="checkbox"/> Yes <input type="checkbox"/> No			Emergency Contact				Telephone				
Your Current Problem:				Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Accident Case? <input type="checkbox"/> Yes <input type="checkbox"/> No		Automobile Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Due to Work-Related Injury, Fill out the Section Below.											
Date of Injury / /		Was Injury Reported to Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Supervisor							
Employer at Time of Injury			Address				Telephone				
Description of Injury:											
Workers' Compensation Insurance Carrier								Claim Number			
Workers' Compensation Insurance Carrier Address								Telephone			
<p>By signing this form I am accepting full responsibility for this account. I understand that any insurance estimate given by this office is not a guarantee of actual insurance payment or coverage. I also understand that I am responsible for all charges incurred for medical treatment performed upon my dependents or me. Any insurance claim not paid within 90 days will become my responsibility. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount of any future outstanding account balances.</p> <p>Signing this form does not authorize release of written information. I understand that if information is requested I must sign a separate authorization form (or check yes and list information for persons in which information is released to) for the release of the information as stated in the Notice of Privacy Practices, which is provided by the physician. I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews. By signing this I am stating that I have read the Notice of Privacy Practices and understand all that it entails.</p>											
Patient or Responsible Party											
Signature _____						Date _____					