Registration Form

☐ New ☐ Revision

REGISTRATION DATE	REFERRING PHYSICIAN	PHONE #	PRIMARY CARE PHYSICIAN	PHONE

PATIENT NAME (LAST) (FIRST) (MI)	DATE OF BIRTH	SEX

STREET ADDRESS	SOCIAL SECURITY #

CITY	STATE	ZIP CODE	HOME PHONE #

EMPLOYER	ADDRESS	BUSINESS PHONE #

PERSON TO CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP TO PATIENT	HOME PHONE #	BUSINESS PHONE #

RESPONSIBLE PARTY/SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH

STREET ADDRESS	SOCIAL SECURITY #

CITY	STATE	ZIP CODE	HOME PHONE #

EMPLOYER	ADDRESS	BUSINESS PHONE #

1. Is this visit related to any type of accident (auto, personal injury/liability? ☐ Yes ☐ No
   If yes, Name of Insurance Co._____ Policy #_____
   DOA_____ Claims Address_____
   Claim #_____ Policy Holder's Name_____
   Adjustor's Name_____ Phone #_____
   Attorney's Name_____ Phone #_____

2. Is this visit related to Worker's Compensation? ☐ Yes ☐ No If yes, where should we send the bills for your care? Name of Insurance Carrier or Employer_____
   Address_____ Claim #_____ DOA_____

3. Name of your primary health care coverage_____
   Address_____
   Agreement #_____ Group #_____ Subscriber_____

4.* If covered by Medicare, do either you or your spouse work? ☐ Yes ☐ No If yes, does the employer provide health insurance coverage? ☐ Yes ☐ No
   Employer's Name_____ Phone #_____
   Employer's Address_____
   Name & Address of Insurance Co._____
   Policy #_____ Group #_____ Subscriber's Name_____

5.* Do you have secondary health insurance coverage? ☐ Yes ☐ No If yes, name of insurer: _____ Address_____
   Policy #_____ Group #_____ Subscriber's Name_____

Attach copies of all corresponding insurance cards and insurance forms when applicable.