PATIENT REGISTRATION FORM

DATE: ____/_____/_____ Account #_____ Patients Last Name:_____ _First: _____M Initial_____

Address: _____Apt#____City_____State_____Zip Code_____ Home # _____

Social Security #_____Date of Birth: _____ Cell # _____ Alternate # _____

- Race (Circle One): American Indian or Alaska Native, Asian, African American, Native Hawaiian or Pacific Islander, White, Other_____
- Ethnicity (Circle One): Hispanic or Latino Or Non Hispanic

IF YOU WISH TO ELECT TO REFUSE RACE AND ETHNICITY QUESTIONS USED FOR STATE REPORTING PURPOSES ONLY CIRCLE HERE: **Refused**

Financial Responsible Party (patients under the age 18)

Name_____

Address:_____City_____State_____

Zip: _____. Home #_____ Cell #_____Wrk #_____

Date of Birth: _____ Social Security #_____Patient Relationship_____

Employer: _____Phone #_____

Signature of Patient or Financial Responsible Party_____

PLEASE PROVIDE PICTURE ID OF PARTY SIGNING.

Primary Insurance: _____

Insurance Phone #_____

Insurance Claims Address_____

Subscriber ID: _____ Group #_____ Patient relationship_____

SUBSCRIBER NAME: _____SUBSCRIBER DOB: ___/____/_____SUBSCRIBER SS#_____-_____-_____

Secondary Insurance: _____

Insurance Phone #_____

Insurance Claims Address_____

Subscriber ID: _____ Group #_____ Patient relationship_____

SUBSCRIBER NAME: _____SUBSCRIBER DOB: ___/____/_____SUBSCRIBER SS#_____-_____-_____

EMERGENCY CONTACT INFORMATION OF SOMEONE NOT LIVING WITH PATIENT

NAME: _____ ADDRESS: _____

PHONE _____RELATIONSHIPT TO PATIENT_____

- ***PLEASE NOTE: WORKERS COMPENSATION OR AUTO ACCIDENT***

*IF YOUR SERVICES ARE TO BE PAID BY YOUR **WORKERS COMP OR AUTO INSURANCE**, YOU MUST SUPPLY US WITH APPROPRIATE DOCUMENTATION, IF DOCUMENTATION IS NOT SUPPLIED YOU WILL BE HELD RESPONSIBLE FOR THE BALANCE DUE.*
WE MUST HAVE CLAIM#_____ ***CASE WORKER***_____

DATE OF INJURY_____ ***PHONE #*** _____

IF ATTORNEY IS HANDLING YOUR CASE PLEASE FILL OUT BELOW

NAME_____***ADDRESS***_____

PHONE: _____