PATIENT REGISTRATION FORM

DATE: ___/___/___ Patient's Last Name: ______________ First: ______________ M Initial: ______

Address: ______________ Apt #: ______ City: ______________ State: ___ Zip Code: __________

Social Security #: ______________ Date of Birth: ______________ Cell #: ______________ Home #: ______________

Email Address: ______________________________

1. DEMOGRAPHICS

- 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
- Sex (Circle One): Male Female

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

2. FINANCIAL

Financial Responsible Party (patients under the age 18)

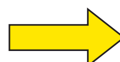
Name: ______________________________

Address: ______________________________ City: ______________ State: ___ Zip Code: ________

Home #: ______________ Cell #: ______________ Work #: ______________

Date of Birth: ______________ Social Security #: ______________ Patient Relationship: ______________

Employer: ______________________________ Phone #: ______________



Signature of Patient or Financial Responsible Party X______________________________

PLEASE PROVIDE PICTURE ID OF PARTY SIGNING.

3. INSURANCE

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#: ____-____-________

4. EMERGENCY CONTACT

EMERGENCY CONTACT INFORMATION OF SOMEONE NOT LIVING WITH PATIENT

NAME: ______________________________ ADDRESS: ______________________________

PHONE: ______________________________ RELATIONSHIP TO PATIENT: ______________

5. WORKERS COMP OR AUTO ACCIDENT

- ***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 #: ______________________________