

PATIENT REGISTRATION FORM

- Please provide a copy of your current insurance cards.
- Co-Pay, Co-Insurance & Deductibles are expected at the time of service.

Patient Information:

Last Name: _____

Date of Birth: _____

First Name: _____

Patient Gender: Male ___ Female ___

Middle Name: _____

Marital Status: _____

Address: _____

Student: Yes ___ No ___

City, State, Zip: _____

Employer Name: _____

Home Phone#: (____) _____

Address: _____

Cell Phone#: (____) _____

City, State, Zip: _____

Social Security #: _____

Phone: (____) _____

Occupation: _____

Referring Physician:

Name: _____

Family/PCP Physician:

Name: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

Phone#: (____) _____

Phone: # (____) _____

Fax#: (____) _____

Fax# (____) _____

Guarantor Information:

(Person responsible financially and/or patient is a minor)

Last Name: _____

Date of Birth: _____

First Name: _____

Social Security #: _____

Middle Name: _____

Employer Name: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

Home Phone#: (____) _____

Phone #: (____) _____

Relationship to Patient: _____

Emergency Contact:

*****Please list name of someone not living in your household*****

Name: _____

Address: _____

Phone#: Wk. (____) _____ Hm. (____) _____

Relationship to Patient: _____

INSURANCE INFORMATION:

*** Insurance Cards/Documentation must be given to front desk at time of service ***

Will this treatment be done as a result of:

• Workers Compensation Injury: Yes ___ No ___

Date of Injury: _____ WC Claim #: _____

Managed Care Organization: _____

Claims Representative: _____ Phone #:(____)_____

• Auto/Personal Accident: Yes ___ No ___

Date of Injury: _____ Claim #: _____

Auto/Home Owners Insurance: _____

Claims Representative: _____ Phone #:(____)_____

Health Insurance:

Primary Insurance: _____

Policy/ID #: _____

Group #: _____

Insured/Subscriber: _____

Social Security #: _____ Date of Birth: _____

Relationship to Patient: _____

Insured Employer: _____

Effective Date: _____ Referral Required Yes ___ No ___

Secondary Insurance _____

Policy/ID #: _____

Group #: _____

Insured/Subscriber: _____

Social Security #: _____ Date of Birth: _____

Relationship to Patient: _____

Insured Employer: _____

Effective Date: _____ Referral Required Yes ___ No ___

INSURANCE AUTHORIZATION/ASSIGNMENT (PLEASE READ & SIGN)

I hereby authorize the physician to furnish information to my insurance carrier concerning my condition and treatment. I hereby assign to the physician all payments for medical service rendered to my dependent or myself. I understand that I am responsible for any amount not covered by my insurance carrier. I agree to be held responsible for collection processing fees that may be added to my account if collection action occurs.

Signature _____ Date _____
(If the patient is a minor, the legal guardian must sign)

PATIENT MEDICAL INFORMATION

What condition(s) are you being seen for today?

Please circle any of the following conditions that you currently have or have had.

- | | | |
|---------------------|-----------------------|-----------------------|
| High Blood Pressure | Respiratory Condition | Arthritis |
| Low Blood Pressure | Asthma | Circulatory Condition |
| Heart Condition | Seizures | Liver Condition |
| Kidney Condition | Bleeding Tendencies | Venereal Disease |
| Diabetes | Gout | Infectious Disease |
| Allergies | Thyroid | HIV + |

Other:

Have you had metal (ex. plates, screws, rods) implant surgery? Yes ___ No___

Height: _____ Weight: _____ Shoe Size: _____ Mens: _____ Womens: _____

Narrow: _____ Regular: _____ Wide: _____

Smoker? Yes ___ No ___ If yes, how long? _____ How many packs a day? _____

Sensitive to Latex? Yes _____ No _____

Sensitive to Adhesive? Yes _____ No _____

List any drug Sensitivities/Allergies: _____

List Prescription Medications Currently Taking: (Attach list if additional space needed)

