

PATIENT REGISTRATION
PLEASE PRINT & COMPLETE ALL PORTIONS



Chart No. _____

Today's Date Mo. _____ Day _____ Year _____

PRIMARY CARE PHYSICIAN: _____
PART OF BODY TO
BE TREATED: _____

HAVE YOU EVER BEEN TREATED BY
ONE OF OUR DOCTORS Yes No

REFERRED BY: _____
Physician, Attorney, Other

SMOKER NON-SMOKER

DOCTOR: _____

PATIENT NAME: _____ SEX: _____

DATE OF BIRTH: _____ AGE: _____

MAILING ADDRESS: _____
Street or Box Number City State Zip

HOME TELEPHONE: _____

SOCIAL SECURITY#: _____

E-MAIL: _____

MARITAL STATUS: (check one) Married Unmarried Separated

PATIENT'S EMPLOYER: _____

OCCUPATION: _____

EMPLOYER'S ADDRESS: _____
Street or Box Number City State Zip

EMPLOYER'S PHONE: _____

PRIMARY INSURANCE: _____ POLICY or GROUP NO.: _____ I.D. NO.: _____

PRIMARY INSURANCE ADDRESS: _____
Street or Box Number City State Zip

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE: _____ POLICY or GROUP NO.: _____ I.D. NO.: _____

SECONDARY INSURANCE ADDRESS: _____
Street or Box Number City State Zip

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

GUARANTOR/GUARDIAN: _____ DATE OF BIRTH: _____ OCCUPATION: _____
GUARANTOR/GUARDIAN EMPLOYER: _____ EMPLOYER'S PHONE: _____

ADDRESS: _____
Street or Box Number City State Zip

GUARANTOR/GUARDIAN ADDRESS IF DIFFERENT FROM PATIENT'S ABOVE: _____

Street or Box Number City State Zip PHONE: _____

INJURY: Yes No If yes, complete the following:

HOW DID IT HAPPEN? _____

DATE OF INJURY: _____ WHERE? _____

Did injury occur on-the-job? Yes No Claim No.: _____ Adjuster name: _____

EMPLOYER AT TIME OF INJURY: _____

EMPLOYER'S WORKER'S COMPENSATION INSURANCE CARRIER: _____

ADDRESS COMPENSATION INSURANCE CARRIER: _____
Street or Box Number City State Zip

IN CASE OF EMERGENCY CONTACT: _____ Relationship: _____

Street or Box Number City State Zip Telephone: _____

ACKNOWLEDGEMENT OF FINAL RESPONSIBILITY and ATTESTATION OF ACCURACY OF INFORMATION

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional and medical services rendered. I have read all of the information on both sides of this registration form and have provided the above information. I certify this information is true and correct to the best of my knowledge. I will notify you immediately of any changes in my status or the above information

Please, review and sign the reverse of this form.

Patient/Legally Authorized Representative Signature: _____ Date _____