PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks.

Patient Name (Last, First, Middle Initial)	Date of Birth	Sex M / F	Age	Social Security Number
Select One: Minor Single Married Divorced Widowed Separated		Home Telephone Number		E-mail address
Home Address	City		State	Zip
Mailing Address if Different	City		State	Zip
Pharmacy Name	Location		Pharmacy Telephone Number	
Employer's Name		Work Telephone Number		
Employer's Address	City		State	Zip
Spouse Name	Social Security Number			Date of Birth
Employer's Name		Work Telephone Number		
Employer's Address	City		State	Zip
Referring Physician	Phone Number		Address	

NOTIFY IN CASE OF EMERGENCY

Name	Relationship
Home Telephone	Work Telephone

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name		Relationship	
Address	City	State	Zip
Home Telephone	Work Telephone		

INSURANCE INFORMATION

Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#	
Insurance Company		Telephone Number	
Address	City	State	Zip
Relationship to Patient	Group Number	Policy Number	
Union or Local Number	Deductible Amount	Maximum Benefit Amount	

Do you have any additional insurance? ❒ No ❒ Yes (please list)

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Were you injured on the job? ❒ Yes ❒ No	Have you informed your employer? ❒ Yes ❒ No		
Date of original injury:	Workers Compensation Carrier Name:		
Address	City	State	Zip
Phone Number	Group Number	Policy Number	

AUTHORIZATION AND RELEASE

I authorize release of any information concerning my healthcare, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also herby authorize payment of insurance benefits, otherwise payable to me, directly to the clinic.

Signature of patient:____ Date:____________________

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