

PATIENT REGISTRATION

Welcome to our clinic. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Patient's Name		Sex M F	Birth Date ____/____/____ Age _____	Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
Residence address		City	State	Zip	Home Phone: _____
Patient's Social Security #					
Guarantor		Self Spouse	Guarantor Birth date ____/____/____		Guarantor's Social Security #
Name of employer		Address or ___ Not Applicable		Business Phone	Occupation
Reason for Visit:		Referred by: (include address and phone)			
Person to contact in case of emergency:			Relationship to patient		Phone
Medicare Yes <input type="checkbox"/> No <input type="checkbox"/>	Medicare #		Medicaid Yes <input type="checkbox"/> No <input type="checkbox"/>	Medicaid #	
Effective Date					
Medicare Secondary insurance name		Address		Policy #	Group #
Workers' Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/>	Motor Vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #
If Yes-put W/C or MVA carrier below					
Primary insurance company				Address	
				Is insurance through your employer?	
Subscriber Name		Subscriber birth date		Policy #	Group #
Secondary insurance name		Address		Policy #	Group #

Lifetime Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits to _____ for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

I have received a copy of my Patient Rights and Responsibilities and this facility's Grievance Procedure.

Patient, Parent or Guardian Signature (if child is under 18 years old)

Date