

**PATIENT REGISTRATION**

**Today's Date** \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_ Social Security # \_\_\_\_\_  
Street  
City State Zip  
Please circle Single Married Divorced Widowed Separated

E-mail address \_\_\_\_\_ How Many Children \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Spouse's Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Spouse Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_ Employer's Address \_\_\_\_\_

Employer's Phone (\_\_\_\_\_) \_\_\_\_\_ Employer's Phone (\_\_\_\_\_) \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Chief complaint \_\_\_\_\_

Have you consulted any other doctors for these complaints? If yes: Who? \_\_\_\_\_

Who is your Family Doctor? \_\_\_\_\_ Phone \_\_\_\_\_

you have x-rays taken? Yes No Where? \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable

**BILLING INFORMATION:**

**PAYMENT IS EXPECTED AT THE TIME OF VISIT!!**

1. Is this a **Worker's Comp.** Problem/injury? No Yes If yes: Date of injury \_\_\_\_\_

Have you reported this injury? Yes No Worker's Comp. Claim # \_\_\_\_\_

2. Is this problem/injury the result of an **accident**? No Yes If yes: Date of accident \_\_\_\_\_

3. Do you have an attorney? Yes No Name \_\_\_\_\_ Phone \_\_\_\_\_

**Primary Insurance** (the insurance company that pays first)

Name of Insurance \_\_\_\_\_

Whose name is it in? \_\_\_\_\_ Date of Birth \_\_\_\_\_

I.D. Number \_\_\_\_\_ Group/Policy Number \_\_\_\_\_

**Secondary Insurance** (the insurance that pays after primary insurance has paid)

Name of Insurance \_\_\_\_\_

Whose name is it in? \_\_\_\_\_ Date of Birth \_\_\_\_\_

I.D. Number \_\_\_\_\_ Group/Policy Number \_\_\_\_\_

I state that I am not currently a debtor in a pending Chapter 7 or Chapter 13 Bankruptcy Proceeding. (Patient Initials) \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_