

NEW PATIENT REGISTRATION

Marital Status (Check One) Single Divorced Widow Married

Patient Name: _____ **DOB:** _____ **SS#:** _____

Home Phone: _____ **Cell Phone:** _____ **Responsible Party/Relation:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Insurance: _____ **ID#:** _____ **Group#:** _____

Policy Holder: _____ **Relationship:** _____ **SS#:** _____ **DOB:** _____

Employer: _____ **Job Title:** _____ **Work Phone:** _____

Secondary Insurance: _____ **ID#:** _____ **Group#:** _____

Policy Holder: _____ **Relationship:** _____ **SS#:** _____ **DOB:** _____

Employer: _____ **Job Title:** _____ **Phone:** _____

Referring Physician: _____ **Address:** _____ **Phone:** _____

PCP: _____ **Address:** _____ **Phone:** _____

Specialist: _____ **Address:** _____ **Phone:** _____

MRI/CT Scans/X-Rays (Where performed): _____ **When:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Is this accident related? Y N **Type:** Motor Vehicle Work Comp Other _____ **Accident State:** _____ **Date:** _____

Were you at fault? Y N **Do you have a Liability?** Y N **Are you claiming it on No-Fault Insurance** Y N

Auto Ins _____ **Claim #** _____ **Phone:** _____ **Fax:** _____

Is there Med Pay available? Y N **Policy limits:** \$ _____ **Agents Name:** _____

Is there a Lien? Y N **Attorney:** _____ **Phone:** _____ **Fax:** _____

Workers Comp Carrier: _____ **Phone:** _____ **Fax:** _____

Case Worker: _____ **Claim #:** _____ **Date of Injury:** _____ **Injury Site:** _____

Did you sustain an injury at work? Y N

Are your injuries accident related? Y N

Are you currently employed? Y N

Are you covered under an employer or union policy? Y N

Is your spouse or other family member employed? Y N

Do you have a secondary insurance policy? Y N

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers completely. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information as I know it is my responsibility to do so. I additionally agree that if my account is sent to collection due to failure to pay, I will be financially responsible for including a 35% collections fee, other collection fees, court costs, attorney fees and any other fees incurred due to my debt.

Patient Signature/Guardian Signature

Date

Witness

Date

For Internal Use Only

DEA: _____ **Meds/Bottles:** _____ **CL:** _____ **Appt Date:** _____ **Appt Time:** _____ **Employee:** _____ **Length of Appt:** _____