Patient Registration

Date_____ (PLEASE PRINT)

Patient Information

Name_____ SS # _____
Last Name First Name MIddle Initial

Address_____ City_____ State_____ Zip _____

Home Phone_____ Cell Phone_____ Email_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married

Patient Employer/School_____ Occupation _____

Employer/School Address _____ Employer/School Phone(____)_____

In case of Emergency who should be notified?_____ Phone (____) _____

My condition is related to: ☐ Work ☐ Auto Accident (State_____) Date of Injury_____ ☐ Other _____

Work Status: ☐ Currently Employed: ☐ Retired ☐ Disabled (_____total or ____ temporary) ☐ Student (_____P/T_____F/T)

Referral Information *(ALL INFO REQUIRED)*

How did you hear about us? _____

If by a friend or family member, please provide a phone number and address so that we may send a thank you note.

_____

Primary or Referring Physician Name _____

When is your next visit with this physician? _____

Payment Information

Person Responsible for Account_____
Last Name First Name MIddle Initial

Relation to Patient_____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone (_____) _____

City_____ State_____ Zip_____

Person Responsible Employed by _____ Occupation _____

Insurance Company_____

Contract #_____ Group # _____ Subscriber # _____

(Check only one box)

I am paying by **CASH, CHECK, CREDIT** and would like a...

☐ 30% discount by paying at the time of service.

☐ Payment plan, Fees may apply.

I have **INSURANCE** and would like to...

☐ Have you deal directly with them.

☐ Other_____

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient