REGISTRATION INFORMATION

(please print)

Patient Name_____
Last Name First Middle Initial

Address_____
Street City State Zip Code

Home Phone( )_____Cell( )_____Wk ( )_____

Birthdate_____Age_____ Sex : Male____Female_____

Patient's Social Security Number: _____ ___ _____Dr. Lic. #_____State____

Marital Status Married___Single___Widowed___Divorced___Separated_____

Employer_____Phone_____

Employer Address_____

Occupation_____

Responsible Party Name (IF NOT PATIENT)_____

Social Security Number _____ _____ _____ Date of Birth:_____

Address if different from above:_____

Phone number (_ ___)_____Cell ( )_____

Employer_____Phone_____

Employer_____Phone_____

Name of **spouse** (If married)_____ _____

Date of Birth:_____Social security #_____ __ __ _____

Employer:_____Phone_____

PrimaryInsurance _____Phone_____

Address_____

Group_____ID_____

Subscriber_____Employer:_____

Secondary Insurance_____ Phone_____

Address_____

Group_____ ID_____

Subscriber_____ Employer_____

Date of injury or onset of problem_____

Referred by_____

Primary Care/Family Physician_____

Address_____ Phone_____

Injured while at work? Yes_____ No_____ Not Sure_____

In case of emergency, notify_____

Address_____ Phone_____

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF INSURANCE BENEFITS:

The undersigned hereby authorizes treatment by providers at this facility. I also authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes the physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I,_____hereby authorize
(Name of insured)

my insurance company of record to pay and assign directly to the treating physician at this facility all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to the provider will be credited to my account, in accordance with the above said assignment.

Signed_____ Date_____