

PATIENT REGISTRATION (PLEASE PRINT)

Primary Care Physician _____		Address: _____	
		Phone: _____	
Referred By _____		Address: _____	
		Phone: _____	
Have you been a patient here before? Yes/No If yes, when,			
Is this Work related? Yes/No (If yes, see back) Auto? Yes/No Other? Yes/No Date of Injury			
Patient Name	Last	First	Middle
Birth date		Age	Social Security #
Street Address		P.O. Box/Apt #	
City	State	Zip Code	
Phone# Home	Work	Ext:	Cell
May we contact you at work? If yes, during what hours?			
Health Insurance			
Primary Insurance Company			
Name:			
Contract/Identification#		Copay amount	
Group#		Effective date	
Subscriber's Name (carries the insurance)			
Relationship		Subscribers Date of Birth	
		Subscribers Social Security #	
Employer Name		Employer Address	
Secondary Insurance Company			
Name:			
Contract/Identification#		Copay amount	
Group#		Effective date	
Subscriber's Name: (carries the insurance)			
Relationship		Subscriber's Date of Birth	
		Subscriber's Social Security #	
Employer's Name		Employer Address	
Guarantor: Person financially responsible if patient is a minor			
Name:		Relationship:	
Address:		Phone#:	
CONTACT PERSON: Please identify who may be contacted in emergency.			
Name:		Phone:	

WORKER'S COMPENSATION CLAIM INFORMATION

Name:		Social Security#
Date of Injury	Last Day Worked	County of Injury
Employer:		Employer Phone#:
Employer Address:		
City, State, Zip		
Have you gone back to Work? Y N		If yes, Date of Return:
Are you working with restrictions? Y N		Type of Restrictions:
Has your employer been notified of this injury? Y N		
Did your employer file the <i>Employer's Basic Report of Injury</i> form 100?		
If yes, please provide a copy		
Work Comp Carrier:		
Carrier Address:		
City State Zip		
Contact/Case Manager		Phone#
Claim Number:		
Is this case in dispute? Y N		
Is an attorney involved? Y N		
Attorney Name:		
Attorney Address:		
<p>I understand that my employer's Worker's Compensation insurance carrier will be billed for all services. It is the policy of this office to require prior authorization and I understand that it is my responsibility to provide that authorization. I understand that this provider is entitled to bill my health insurance through subrogation, if the Worker's Compensation carrier denies payment due to dispute. In the event that I do not have health insurance, I understand that I will be held responsible for payment for those services.</p>		
Signature:		Date: