PATIENT REGISTRATION - *Please Print* **PLEASE USE BLACK INK**

Patient : ☐ Male ☐ Female____
Last Name First Name Middle Initial

Social Security Number:______________________Date of Birth ____________ Age: ______

Mailing Address____
City State Zip

Street Address____
City State Zip

Home Phone ____________________ Alternative Phone________________E-Mail____________________

Spouse/Significant Other Name:________________________

Who referred you to this office?____________________Driver License Number:________________

Primary Care Physician:____________________Location (city & state):________________

PARTY RESPONSIBLE FOR BILL, IF NOT PATIENT

Name:____

Mailing Address____
City State Zip

Phone ________________________ Relationship to patient: ☐Self ☐Spouse ☐Child ☐Dependant

EMPLOYMENT HISTORY

Employer____________________________Work Phone________________

Employer Address____________________________Occupation:________________

IF INJURED: Date the accident happened________________Place: ☐ Home or School ☐ Work ☐ Auto Accident

IF NOT INJURED: Nature or cause of pain________________Duration of pain:________________

EMERGENCY CONTACT (local friend or relative, not living with you)

Name________________________ Relationship to Patient________________

Home Phone________________________ Alternative Phone ________________

INSURANCE INFORMATION ☐ **Medical Insurance** ☐ **Workman's Comp** ☐ **Auto Insurance** ☐ **Cash Pay**

Primary________________**Copay**__________ **Secondary**________________**Copay**__________

Subscriber's Name____________________ **Subscriber's Name**____________________

ID# ____________________ **ID#** ____________________

Group # ____________________ **Group#** ____________________

Subscribers Birth date ____________________ **Subscribers Birth date**____________________

Patients Relationship: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Dependent** **Patients Relationship:** ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Dependent**

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim.

PLEASE SIGN____ **Date**______________