Patient Registration Form

Demographic Information

Name:_____ **Date of Birth**:_____ **Sex**: M☐ F☐

SS #:_____ **Home Phone #**: ( )_____

Cell Phone #: ( )_____ **Work Phone #**: ( )_____

Address:_____ **City**:_____ **State**:_____ **Zip Code**:_____

Email address:_____ **Preferred language**:_____

Race: Caucasian Hispanic African American Biracial Asian Other:_____ Decline

Ethnicity: Hispanic Non-Hispanic Decline **Marital Status**: Single Married Widowed Divorced

Employer: _____ **Address**: _____

Emergency Contact: _____**Relationship**:_____**Phone #**:( )_____

Authorized to Disclose Health/Billing information to emergency contact? Yes☐ No☐

Insurance Information

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

Subscriber:_____ **Relationship to Subscriber**:_____

Subscriber's Date of Birth:_____

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

Subscriber:_____ **Relationship to Subscriber**:_____

Subscriber's Date of Birth:_____

Appointment related to a work injury or an auto accident?

Type: Auto Accident Worker's Comp Legal/Employer Other **Date of accident/injury**:_____

State of accident/injury:_____ **Auto Accident/Worker's Comp Insurance Carrier**:_____

Phone #: ( )_____ **Address**: _____ **City**:_____

State:_____ **Zip Code**:_____ **Auto Insurance/Worker's Comp Claim #**:_____

Adjuster's name:_____ **Phone #**: ( ) _____

Signed: _____ **Date:** _____ **Relationship to Patient:** _____