# PATIENT REGISTRATION

Welcome to our clinic. In order to serve you properly, we will need the following information. **(Please Print)**ll information will be strictly confidential.

| | | | |
|---|---|---|---|
| Patient's Name | Sex<br>M<br>F | Birth Date ____/____/_____<br><br>Age_____ | Marital Status<br>Single [ ] Married [ ]<br>Widowed [ ] Divorced [ ] |
| Residence address City State Zip | | Home Phone: | Patient's Social Security # |
| Person financially responsible for this account | Self<br>Spouse | Responsible Party's Birthdate<br>____/____/_____ | Responsible Party's Social Security # |
| Responsible Party<br>Drivers License # State: Number | | Occupation | How Long at current Employer? |
| Name of employer Address **or** ___ **Not Applicable** | | Business Phone | Occupation |
| Reason for Visit: | Referred by: (include address and phone) | | |
| Person to contact in case of emergency: | Relationship to patient | Phone | |

| | | | | |
|---|---|---|---|---|
| **Medicare** Ye s **[ ]**<br>No **[ ]** | Medicare # | Medicaid Yes **[ ]**<br>No **[ ]** | Medicaid # | Effective Date |
| Medicare Secondary insurance name Address | | | Policy # | Group # |

| | | | | |
|---|---|---|---|---|
| Workers' Compensation? Yes **[ ]** No **[ ]**<br>Motor Vehicle? Yes **[ ]** No **[ ]**<br>**If Yes-put W/C or MVA carrier below** | Date of Accident | Treatment authorized by | Claim # | W/C or MVA Insurance Phone # |
| Primary insurance company Address | | | | Is insurance through your employer? |
| Subscriber Name | Subscriber birth date | Policy # | | Group # |
| Secondary insurance name Address | | | Policy # | Group # |

Do you have an Advanced Directive? Yes ( ) No ( ), If yes a copy must be provided to the clinic.

**Lifetime Assignment of Benefits / Information Release / Authorization to Treat:**

I authorize payment of medical benefits to _____ for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

I have received a copy of my Patient Rights and Responsibilities and this facility's Grievance Procedure.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date