

# PATIENT REGISTRATION FORM

TODAY'S DATE \_\_\_\_\_

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FOR OFFICE USE ONLY: ACCOUNT # \_\_\_\_\_ PATIENT # \_\_\_\_\_ NEW \_\_\_\_\_ UPDATE \_\_\_\_\_

## PATIENT INFORMATION

LAST	FIRST	MI	HOME PHONE	CELL
ADDRESS			WORK PHONE	
CITY	STATE	ZIP	EMPLOYER	
SOCIAL SECURITY NUMBER			MARITAL STATUS : SINGLE MARRIED OTHER	
BIRTHDATE			SEX: M F	
			STUDENT STATUS: FULL PART-TIME	

## INFORMATION FOR PERSON RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE (GUARANTOR)

Mr Mrs Ms Miss	HOME PHONE
Last First MI	
ADDRESS	WORK PHONE
CITY STATE ZIP	EMPLOYER
SOCIAL SECURITY NUMBER	POSITION
RELATIONSHIP TO PATIENT:	EMPLOYER ADDRESS

## IS THE PATIENT COVERED BY MEDICAL INSURANCE? YES NO

INSURANCE INFORMATION	PRIMARY INSURANCE	SECONDARY INSURANCE**	OTHER INSURANCE
INSURANCE NAME			
SUBSCRIBER'S NAME			
SUBSCRIBER'S EMPLOYER			
SUBSCRIBER'S ID # OR SOCIAL SECURITY NUMBER			
GROUP, MEMBER # OR CLAIM #			
SUBSCRIBER'S BIRTHDATE & SEX: M F			
SUBSCRIBER'S ADDRESS (IF DIFFERENT FROM PATIENT)			
SUBSCRIBER'S PHONE (IF DIFFERENT FROM PATIENT)			
RELATION OF PATIENT TO SUBSCRIBER			
SUBSCRIBER'S WORK PHONE			

\*\*MEDICARE PATIENTS ONLY  
PLEASE CHECK APPROPRIATE BOX

SUPPLEMENTAL INSURANCE IS  
PROVIDED BY PATIENT (MG)

SUPPLEMENTAL INSURANCE IS  
PROVIDED BY FORMER  
EMPLOYER (SP)

CONTINUED ON OTHER SIDE->

IS THIS INJURY JOB-RELATED? YES \_\_\_\_\_ NO \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

STATE FUNDED CLAIM \_\_\_\_\_ SELF-INSURED CLAIM \_\_\_\_\_ BODY PART \_\_\_\_\_

CLAIM # \_\_\_\_\_ EMPLOYER OF INJURY \_\_\_\_\_

CLAIMS MGR NAME \_\_\_\_\_ CLAIMS MGR PHONE \_\_\_\_\_

BRIEFLY DESCRIBE INJURY \_\_\_\_\_

WHERE DID THE INJURY OCCUR? \_\_\_\_\_

**ADDITIONAL CLAIM/AUTO ACCIDENT**

DATE OF INJURY \_\_\_\_\_

CLAIM #/POLICY # \_\_\_\_\_ EMPLOYER OF INJURY \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

CLAIMS MGR/CONTACT NAME \_\_\_\_\_ CLAIM MGR/CONTACT PHONE \_\_\_\_\_

BRIEFLY DESCRIBE INJURY \_\_\_\_\_

WHERE DID THE INJURY OCCUR? \_\_\_\_\_

**IF YOU HAVE QUESTIONS REGARDING THE STATUS OF YOUR CLAIM OR YOU ARE WAITING AUTHORIZATION FOR A SURGICAL OR DIAGNOSTIC PROCEDURE, PLEASE CONTACT YOUR CLAIMS MANAGER AT THE DEPARTMENT OF LABOR & INDUSTRIES OR AT YOUR SELF-INSURED EMPLOYER'S WORKERS' COMPENSATION ADMINISTRATOR.**

NAME OF DOCTOR WHO REFERRED YOU: \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_  
Last First M.I.

RELATION TO PATIENT \_\_\_\_\_

HOME PHONE ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

The above information is true to the best of my knowledge. I understand I am responsible for charges associated with medical services and agree to pay all bills within 30 days from the receipt of statement, unless other arrangements are made. I authorize the physician and clinic to release any information to process insurance claims. I also authorize my insurance to be paid directly to the clinic.

PATIENT SIGNATURE \_\_\_\_\_

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_