

**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 <b>Work</b> related? Yes/No (If yes, see back) <b>Auto?</b> Yes/No ( <b>If yes, see auto form</b> ) <b>Date of Injury:</b>			
<b>Patient Name:</b>	Last	First	Middle
<b>Birth date:</b>	<b>Age:</b>	<b>Social Security #:</b>	<b>Driver's License#:</b>
<b>Street Address:</b>		<b>P.O. Box/Apt #:</b>	
<b>City:</b>	<b>State:</b>	<b>Zip Code (to include 4 digit suffix):</b>	
<b>Phone# Home:</b>	<b>Work:</b>	<b>Ext:</b>	<b>Cell:</b>
<b>May we contact you at work?</b>		<b>If yes, during what hours?</b>	
<b>HEALTH INSURANCE</b>			
<b>Primary Insurance Company:</b>			
Name: _____			
Contract/identification#:		Co-payment amount:	
Group#:		Effective date:	
Subscriber's Name (Policy Holder/Name may appear on insurance card):			
Relationship:		Subscriber's Date of Birth:	
		Subscriber's Social Security #:	
Employer Name:		Employer Address:	
<b>Secondary Insurance Company:</b>			
Name: _____			
Contract/identification#:		Co-payment amount:	
Group#:		Effective date:	
Subscriber's Name (Policy Holder/Name may appear on insurance card)			
Relationship:		Subscriber's Date of Birth:	
		Subscribers Social Security #:	
Employer Name:		Employer Address:	
Guarantor: If patient is a minor, the individual bringing in the minor is financially responsible and must complete this section.			
Name:		Relationship:	
Address:		Phone#:	
Guarantor Date of Birth:		Guarantor Social Security#:	
<b>Contact Person:</b> Please identify who may be contacted in emergency.			
Name:		Phone#/s:	

## 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 form 100</i> ?		
<b>If yes, please provide a copy</b>		
Work Comp Carrier:		
Carrier Address:		
City/State/Zip (to include 4 digit suffix if known):		
Contact/Case Manager/Adjuster's Name:		Phone#/s:
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 of those services.</p>		
Signature:		Date: