Registration Form

Please Print. Patients under the age of 18 need to have a parent/guardian complete and sign.

Patient Name (Last, First, Middle Initial) _____ **Date of Injury** _ _ /_ _ / _ _ _ _

Social Security # _____ Date of Birth _____ **Cause of Injury (check one)**

Age _____ Sex: Male □ Female □ Marital Status _____ _____ Auto Accident

Guardian (If patient minor) _____ _____ Workers Compensation

Guardian Date of Birth _____ _____ Other

Address _____ Apartment # _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Email _____

Employer _____ City _____ State _____ Zip _____

Employer Phone # _____

Referring Physician _____ Primary Care Physician _____

How did you hear about us? _____

Primary Health Insurance Company _____

Policy # _____ Group # _____

Policy Holder Name _____ Date of Birth _____ Relationship to Patient _____

Policy Holder Social Security # _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____

Policy Holder Name _____ Date of Birth _____ Relationship to Patient _____

Policy Holder Social Security # _____

Emergency Contact & Relationship _____ **Phone #** _____

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; they sometimes refer to as "Reasonable and customary fees." We do not accept this as payment in full (unless otherwise restricted by law or agreement we may have with your insurer). Also some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance. **IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT**. In the event the account is turned over for collections, the collection fees and /or legal fees, including attorney fees, shall be your responsibility. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to the facility listed in the top header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy.

_____ _____

Patient/Guardian Signature Date

_____

Print Name