

**PATIENT REGISTRATION FORM**

TELL US ABOUT YOURSELF:     ADULT                       MINOR                      TODAY'S DATE: \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

DOMINANT HAND:     RIGHT     LEFT    DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX:     MALE     FEMALE  
 SOCIAL STATUS:     SINGLE     MARRIED     DOMESTIC PARTNERSHIP     SEPARATED/DIVORCED     WIDOW

ADDRESS: \_\_\_\_\_ APT/UNIT#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_

\*\*E-MAIL: \_\_\_\_\_ **\*\*Note:** Please read disclaimer in the **Release of Information Authorization Form**.

**(\*NECESSARY FOR BILLING PURPOSES):**

\*SOCIAL SECURITY#: \_\_\_\_\_ I.D.# / DRIVER'S LICENSE#: \_\_\_\_\_ STATE: \_\_\_\_\_

**EMERGENCY CONTACT NAME:** \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**EMPLOYER NAME:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_ SUITE#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_\_) \_\_\_\_\_

OCCUPATION/TITLE: \_\_\_\_\_

**WERE YOU REFERRED TO OUR OFFICE?**     NO     YES (IF YES, BY WHO?)

NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ SUITE#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_\_) \_\_\_\_\_

**HOW WILL YOUR SERVICES BE PAID?**

CASH-PAY     PPO INS.     OUT OF NETWORK INS.     WORKERS' COMP.     MEDICARE     HMO INS.     OTHER

**COMPLETE THE APPLICABLE PORTIONS OF THIS SECTION IF YOU ARE INSURED:**

**INSURANCE NAME:** \_\_\_\_\_ **INSURANCE CONTACT PERSON:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_\_) \_\_\_\_\_

**NAME OF INSURED:** \_\_\_\_\_ **INSURED'S DATE OF BIRTH:** \_\_\_\_\_

YOUR RELATIONSHIP TO INSURED:     SELF     SPOUSE     CHILD     OTHER: \_\_\_\_\_

**INSURED'S SOCIAL SECURITY NUMBER or SUBSCRIBER I.D.#:** \_\_\_\_\_ **PLAN GROUP NO.:** \_\_\_\_\_

DATE OF YOUR INJURY/ SYMPTOMS ONSET: \_\_\_\_\_ \*WORKERS' COMP CLAIM NO.: \_\_\_\_\_