PATIENT REGISTRATION

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

Patient's Name	Sex **M** **F**	Birth Date ____/____/_____ Age_________	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone:	Patient's Social Security #
Guarantor	Self Spouse	Guarantor Birth date ____/____/_____	Guarantor's Social Security #
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 Yes [ ] No **[ ]**	Medicare #	Medicaid Yes **[ ]** No **[ ]**	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #

Workers' Compensation? Yes **[ ]** No **[ ]** Motor Vehicle? Yes **[ ]** No **[ ]** **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 #

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