PATEINT REGISTATION

(Please print your information and give your license and insurance card to therapist so a copy can be made. Thankyou)

Name______________________________________ Address______________________________________

Home # ______________ Work #_____________ Cell # _____________ Email ____________________

Social Security # _______________Date of Birth ____________ Sex _____ PCP __________________

Employment Status ______________ Employer __________________ Address ____________________

Martial Status ______________ Student Status__________ Medication Allergies _________________

Next of Kin _______________Emergency Contact & Phone # ____________________________________

Name of person who should receive bill (guarantor or responsible party) ______________________________

Relationship to Patient ___________________________ Address _________________________________

Social Security # _______________Date of Birth ____________ Sex _____

Employment Status ______________ Employer __________________ Address ____________________

Primary

Insurance Name ____________________Address _____________________ Phone # _____________

Policy# ____________________ Group # _________________ Group Name _____________________

Subscriber________________ Date of Birth _____________ Relationship to Patient _______________

Secondary

Insurance Name ____________________Address _____________________ Phone # _____________

Policy# ____________________ Group # _________________ Group Name _____________________

Subscriber________________ Date of Birth _____________ Relationship to Patient _______________

Tertiary

Insurance Name ____________________Address _____________________ Phone # _____________

Policy# ____________________ Group # _________________ Group Name _____________________

Subscriber________________ Date of Birth _____________ Relationship to Patient _______________

I understand that I am responsible for my bill. I authorize the release of information necessary to collect any payments to all my insurance companies. I further authorize the release of medical information to all physicians involved in my care. I permit a copy of this authorization to be used in place of the original. I authorize the use of the "signature on file" to be used on all my insurance submissions. I understand that I am responsible for notifying the office of any precertification's or referrals needed for my insurance.

Signature of Patient or Guardian ____ Date ____________________

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