

First Name: \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ AKA \_\_\_\_\_ DOB \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work # \_\_\_\_\_

Email address \_\_\_\_\_ SS # \_\_\_\_\_

\*\*Preferred Method of Contact:  Home  Cell  Work  Email

\*\*May we leave messages about appointments and results? (Check all that apply)  No  Yes

Home  Cell  Work

Gender:  M  F Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Minor Patients:** Child lives with: \_\_\_\_\_ Contact #: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Contact #: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Contact #: \_\_\_\_\_

**Responsible Party, if different than above**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

ID/ SS#: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

ID/SS#: \_\_\_\_\_ Group #: \_\_\_\_\_

Is today's visit related to an accident?  No  Yes Date of Accident \_\_\_\_\_



PATIENT IDENTIFICATION LABEL

REGISTRATION FORM

**If work related, please complete the following questions:**

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_

Allowed Diagnosis: \_\_\_\_\_

MCO: \_\_\_\_\_ Phone#: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone#: \_\_\_\_\_

Have you filed paperwork with your employer?  No  Yes

Do you have an attorney?  No  Yes

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Many of our patients during their recovery may stay with family members, friends or at a rehabilitation or nursing facility. Please provide our office staff with information as to where you are currently staying so we are able to contact you.**

I am staying with a:  Relative  Friend  Rehabilitation Center  Skilled Nursing Facility

Name of Relative/Friend/ Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have a Health Care Power of Attorney?  No  Yes

Name of POA: \_\_\_\_\_ Contact #: \_\_\_\_\_

(If yes, please provide a copy of the POA documents)

**With whom may we contact in case of an emergency or leave medical information with? Indicate whether or not we may discuss medical information pertinent to your treatment with this person.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB \_\_\_\_\_ Phone #: \_\_\_\_\_  No  Yes

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB \_\_\_\_\_ Phone #: \_\_\_\_\_  No  Yes

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB \_\_\_\_\_ Phone #: \_\_\_\_\_  No  Yes

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_