

PATIENT REGISTRATION

Please print legibly

Patient Name _____

Address _____ City/State _____ Zip Code _____

Home Phone _____ Work Phone _____ SS# _____

Medication allergies _____

Sex _____ Birthdate _____ Age _____ Marital Status _____

Emergency Contact _____

Patient's employer or school _____ Occupation _____

Spouse's name _____ Spouse's Date of Birth _____

Spouse's employer _____ SS# _____ Phone _____

Referred by _____ Family physician _____

IF PATIENT IS A MINOR

Mother _____ Date of Birth _____ Home Phone _____

Mother's employer _____ SS# _____ Work Phone _____

Father _____ Date of Birth _____ Home Phone _____

Father's employer _____ SS# _____ Work Phone _____

INSURANCE INFORMATION: Please give the receptionist your card. If you do not have your card with you, we cannot bill your insurance until we receive a copy of both sides of the card.

Primary insurance _____ Secondary insurance _____

INJURY INFORMATION - Work related injuries *must* fill this out completely or you will be responsible for your bill.

Date of Injury _____

Type of Injury (ex. auto, fell, bicycle) _____

Date first unable to work due to this injury _____

IS THIS A WORK RELATED INJURY? YES _____ NO _____

Claim number _____ Claim rep _____

Employer at time of injury _____ Date of injury _____

Do you have an ATTY representing you with your W.C. claim? YES _____ NO _____

ATTY Name _____ Phone _____

Work Comp carrier _____ or Employer's name _____

Address _____ Address _____

City/State _____ City/State _____

Zip _____ Phone _____ Zip _____ Phone _____

AUTHORIZATION, RELEASE & GUARANTEE OF ACCOUNT

I acknowledge that I am responsible for payment in full to Drs. Kahn, Roberts, Kramer or Rohmiller, for services rendered. I also authorize that benefits from insurance companies be paid directly to Drs. Kahn, Roberts, Kramer or Rohmiller. I authorize my attending physician to release any information required by my insurance carrier.

Date _____ Signature _____