PATIENT REGISTRATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST — FIRST — MIDDLE) | DATE OF BIRTH / / | MARITAL STATUS S ☐ M ☐ D ☐ X ☐ W ☐ | SEX M ☐ F ☐ | SOC. SEC. NO. – –

ADDRESS (STREET — CITY — STATE — ZIP) | HOME PHONE ( )

EMPLOYER | F/TIME ☐ P/TIME ☐ RETIRED ☐ NOT EMPL ☐ | OCCUPATION | STUDENT STATUS F/TIME ☐ P/TIME ☐ N/A ☐

EMPLOYER ADDRESS (STREET — CITY — STATE — ZIP) | BUS. PHONE ( )

IF CHILD: FATHER'S NAME/SOC. SEC. NO. – – | DATE OF BIRTH / / | MOTHER'S NAME/SOC. SEC. NO. – – | DATE OF BIRTH / /

IF MARRIED: SPOUSE'S NAME/SOC. SEC. NO. – –

EMPLOYER OF SPOUSE

IN CASE OF EMERGENCY: CONTACT | PHONE ( )

REFERRED BY: | ADDRESS:

FAMILY PHYSICIAN: | ADDRESS:

INDUSTRIAL ACCIDENT? **YES** ☐ **NO** ☐	DATE OF ACCIDENT / /	CLAIM #		**YES**	**NO**
		AUTO ACCIDENT	☐	☐
		PREGNANCY	☐	☐

INDUSTRIAL INSURANCE CARRIER | ADDRESS (STREET — CITY — STATE — ZIP)

INSURANCE INFORMATION "✓" AND COMPLETE

☐ **NO INSURANCE COVERAGE** | ☐ **MEDICARE I.D. #** – – | **MEDI-CAL I.D. #** | **BILL TO:** ____________ **DATE OF BIRTH:** / / | **SEX M** ☐ **F** ☐

☐ PRIMARY INSURANCE | I.D. # | GROUP NO./COV. CODE | NAME OF INSURED | RELATIONSHIP

ADDRESS | PHONE NUMBER ( ) | INSURED'S DATE OF BIRTH / / SEX M ☐ F ☐

☐ SECONDARY INSURANCE | I.D. # | GROUP NO./COV. CODE | NAME OF INSURED | RELATIONSHIP

ADDRESS: | PHONE NUMBER ( ) | INSURED'S DATE OF BIRTH / / SEX M ☐ F ☐

ASSIGNMENT OF INSURANCE BENEFITS

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including MediCare, private insurance and any other health plans to: ______________________
DOCTOR'S NAME

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: ______________________ DATE: ______________________