Patient Registration

Account Number	

☐ Ela

Last Name:		**First Name & initial**	
Address:			
City		**State**	
		Zip	
Phone Number		Have you been examined by our doctors before? ◯ Yes ◯ No	
Date of Birth		Marital Status ◯ Married ◯ Single ◯ Other	
Social Security		Reffered to this office by:	
Employer		**Occupation**	
Address		Is this visit related to work injury? ◯ Yes ◯ No	
		Date of injury:	
City		**State**	
		Zip	
Spouse		Work Phone #	
Spouse D.O.B		Spouse's Work Phone	
Parent/Guardian (For Minor)		**Relationship**	

Insurance Information

- *Please be aware that we will bill your insurance as a courtesy. This office does not accept liens for personal injury, auto accidents or workers' compensation cases.*
- *Does your insurance require authorization for referral to a specialist?* ◯ Yes ◯ No
- *If you have your insurance identification cards, please give them to receptionist.*

Insurance #1					
Address:					
Address:		**State**		**Zip**	
Phone		**Copay**			
Policyholder		**Relationship**	◯ Self ◯ Spouse ◯ Child		
Identification		**Group #**			
Insurance #2					
Address:					
Address:		**State**		**Zip**	
Phone		**Copay**			
Policyholder		**Relationship**	◯ Self ◯ Spouse ◯ Child		
Identification		**Group #**			

Authorization	I authorize my insurance company to make payments directly to this practice. I understand that I am financially responsible to the practice for any service denied by my insurance company. I authorize the release of any information requested with respect to this claim.		
Signature		**Date**	