Account #		**Patient Registration**	☐ Ela

Last Name		First Name/Initial	
Address			
City		State:	Zip:
Phone #		Have you been examined by our doctors before?	☐ Yes ☐ No
Date of Birth		Marital Status	☐ Married ☐ Single ☐ Other
Social Security #		Referred 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	