

# PATIENT REGISTRATION

## SECTION 1: PATIENT INFORMATION

<b>Personal Information</b>	<input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mrs First: _____ MI: ___ Last: _____ Address: _____ City: _____ State: _____ Zip: _____ Email Address: _____ Cell: _____ Home Phone: _____ Work Phone: _____ Emergency Contact Phone: _____ Social Security Number: _____ <input type="checkbox"/> Male or <input type="checkbox"/> Female Marital Status: _____ DOB: _____ Guarantor: _____ Patient Relationship to Guarantor: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Guarantor Address: _____ City: _____ State: _____ Zip: _____ Phone: _____
<b>Physician Information</b>	Referring Physician: _____ Phone: _____ Primary Care Physician: _____ Phone: _____
<b>Condition Information</b>	Are you diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name and address of physician treating your diabetes: Physician Name: _____ Phone: _____ Address: _____ Have you received a similar service in the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you in hospice care? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a resident of a skilled nursing (nursing home) facility? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Was your condition the result of an accident?**  Yes  No *If no, please skip to Insurance Information below.*

**Was your injury work related?**  Yes  No *If yes, name of employer at time of accident:*

Employer Name: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Claim #: \_\_\_\_\_

**Was your injury the result of an automobile accident?**  Yes  No *If yes, name of adjuster:*

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Current Employer: \_\_\_\_\_

## SECTION 2: INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

**Please present the receptionist with your insurance card(s) so we may make copies.**

I certify that the information provided by me is true, accurate and complete.

Signature of Patient / Guarantor \_\_\_\_\_ Date \_\_\_\_\_