Hanger CLINIC
Empowering Human Potential

PATIENT REGISTRATION

SECTION 1: PATIENT INFORMATION

Personal Information

☐Mr ☐Ms ☐Mrs First: _____ MI:___ Last: _____

Address: _____ City: _____ State: ____ Zip: _____

Email Address: _____ Cell: _____

Home Phone: _____ Work Phone: _____

Emergency Contact Phone: _____

Social Security Number: _____

☐ Male or ☐ Female Marital Status: _____ DOB: _____

Guarantor: _____ Patient Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other

Guarantor Address: _____ City: _____ State: ____ Zip: _____

Phone: _____

Physician Information

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Condition Information

Are you diabetic? ☐ Yes ☐ 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? ☐ Yes ☐ No

Are you in hospice care? ☐ Yes ☐ No

Are you a resident of a skilled nursing (nursing home) facility? ☐ Yes ☐ No

Is your injury the result of an injury? ☐ 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*