

PATIENT REGISTRATION

SECTION 1: PATIENT INFORMATION	
Personal Information	Mr/Ms/Mrs First: _____ MI: _____ Last: _____ Address: _____ City _____ State _____ Zip Code _____ Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____ Emergency Contact Phone: (____) _____ Email Address: _____ Social Security Number: _____ Male / Female: <input type="checkbox"/> M <input type="checkbox"/> F 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 Code: _____ Phone (____) _____ Power of Attorney: <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Information	Referring Physician: _____ Phone: (____) _____ Primary Care Physician: _____ Phone: (____) _____
Condition Information	Are you a 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
Is Your Condition the Result of Any Injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, please skip to Insurance Information below.
Was Injury Work Related?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of employer at time of accident: _____ Employer Name: _____ Address: _____ City _____ State _____ Zip Code _____ Contact Person: _____ Phone: (____) _____ Claim #: _____
Was Injury Result of an Automobile Accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of adjuster: _____ Name: _____ Phone: (____) _____ Claim #: _____ Current Employer: _____
SECTION 2: INSURANCE INFORMATION	
Primary Insurance	Primary Insurance: _____ Address/Phone: _____ Policy #: _____ Group #: _____ Name of Insured: _____ Relationship: _____ DOB: _____
Secondary Insurance	Secondary Insurance: _____ Address/Phone: _____ Policy #: _____ Group #: _____ Name of Insured: _____ Relationship: _____ DOB: _____

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