PATIENT REGISTRATION FORM

_____ _____ _____ Last Name First Name Middle Date of Birth: _____ Age: _____ Sex: _____ Social Security #: _____ Home Address: _____ _____ Home Phone:	Occupation: _____ Job Title:_____ Work Address: _____ _____ Work Phone: _____ Work Fax: _____ Cell Phone: _____ E- Mail: _____Pager: _____
PRIMARY INSURANCE Name: _____ Policy # / Group #: _____ Billing Address: _____ _____ Phone: Fax:	**SECONDARY INSURANCE** Name: _____ Policy # / Group #: _____ Billing Address: _____ _____ Phone: Fax:
AUTO ACCIDENT INFORMATION Date of Accident: _____ Place of Accident: _____ State: _____ Police Notified? Insurance Co. notified? Claim Number: _____ Insurance co: _____ Insurance Policy #: _____ Billing Address: _____ _____ Adjuster's Name: _____ Phone: Fax:	**WORKER'S COMP. INFORMATION** Date of injury: _____ Claim Number: _____ Insurance co: _____ Billing Address: _____ _____ Phone: _____ Fax: _____ Adjuster's Name: _____ Employer's Name: _____ Employer's Address: _____ Phone: Fax:
REFERRAL INFORMATION Referring Physician: _____ Address: _____ _____ Phone: ( )_____ Fax: ( ) _____ Reason for Referral:	**PRIMARY CARE PHYSICIAN INFORMATION** Referral Needed: Yes ___ No ___ Co-Pay: $_____ PCP's Name: _____ Address: _____ Phone: Fax:

Insurance Verification: By: _____ On: _____ Spoke to: _____ Records Requested: _____

MEDICO-LEGAL INFORMATION	EMERGENCY CONTACT INFORMATION
Are you in Litigation: Yes _____ No _____	Name: _____
Reason for Litigation: _____	Relationship: _____
_____	Home Address: _____
Lawyer's Name: _____	_____
Para Legal' s Name: _____	Home Phone: ( ) _____
Address: _____	Occupation: _____
_____	Work Address: _____
Phone: ( )_____ Fax: ( ) _____	_____
Do you want your medical records released to your lawyer?	Work Phone: ( ) _____
Yes _____ No _____	Cell Phone: ( ) _____Pager: _____

PHARMACY INFORMATION	PHARMACY INFORMATION
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone: _____Fax: _____	Phone: _____Fax: _____

AUTHORIZATION FOR TREATMENT & FINANCIAL RESPONSIBILITY

I authorize the Physician to provide treatment and to release medical information to my insurance company as may be necessary for payment of physician office claims. I authorize payment directly to my physician of the benefits otherwise payable to me but not to exceed regular charges for physician office claims. I understand that I am financially responsible to my physician for charges not covered by this authorization.

_____ _____

SIGNATURE **DATE**

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the physician to provide copies of my medical records to referring physician(s)/primary care physician(s)/hospital(s)/health care facilities(s)/lawyers/law enforcement authorities when requested. I also authorize my physician to allow managed care organization to access my medical information for quality review purposes.

_____ _____

SIGNATURE **DATE**

MEDICARE PATIENTS

Medicare will only pay for services it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. In that case, I agree to be responsible for payment.

_____

_ SIGNATURE

DATE _____

_____

Patient's Name