



PATIENT REGISTRATION

How did you hear about us?

Internet: Google Yahoo
 Friend/ Family Insurance Co. I am a previous patient Other _____ Doctor: _____

PATIENT INFORMATION

New Patient New Problem Updated Info.

First Name:		Middle Initial:	Last Name:	
Social Security #: --- ---	Date of Birth: / /		Age:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Home Phone:	Cell Phone:		Work Phone:	
Home Address:		City:	State:	Zip Code:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Employer:				
Email Address:		Employed: <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Unemployed Looking for work <input type="checkbox"/> Unemployed, unable to work		
		Occupation: _____		
Who can we contact in case of Emergency:				
Name:		Relationship:	Phone #:	

Do you have medical insurance coverage that you will be using for your doctor visits and treatment? Yes No

Who is the primary person on the insurance plan? It is my plan My husband's/wife's plan Someone Else

Primary Insured's Information:

Last Name:		First Name:		Middle Initial:
Social Security #: --- ---	Date of Birth: / /		Age:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Insured's Employer:				

INSURANCE DETAILS:

My plan is a PPO POS HMO Medicare Medicaid/Peachcare Other: _____
 Insurance Company: _____ My Specialist Co-pay is \$ _____
 Member ID# _____ Group ID # _____

I understand that I will be responsible for all charges incurred by me. Should collection proceedings become necessary, I agree to pay all costs of collection, including reasonable attorney's fees. I hereby assign to and authorize payment directly to the treating physician all benefits payable under the terms of any insurance policy. I realize the insurance benefits may not pay the entire bill(s) and I agree to pay the difference or the entire bill if necessary. I authorize the release of any medical information necessary to process claims on any insurance policy listed above or provided separately.

Patient/Guardian Signature: _____ Date: _____

PATIENT REGISTRATION

HEALTH CLAIM ACCIDENT AND AILMENT QUESTIONNAIRE

Please note that this form is used to determine insurance coverage eligibility and is forwarded to your insurance plan as appropriate.

Patient Name: _____ DOB: _____

Did you have an accident or an injury of any kind? No Yes, Date of accident or injury: _____

If you did not have an accident/injury, describe when you first started having this problem/pain: _____

If it was an accident or injury, did it happen on the job? No Yes

Was this due to an auto accident? No Yes Date of auto accident: _____

Have you hired an attorney in relation to your current health problem? No Yes

Accident Details:

What happened? _____

When did it occur? _____ Where? _____

Have you ever seen anyone for this problem in the past? No Yes When? _____

Is there anything else we should know about your condition or situation? _____

To the best of my knowledge, I attest the information provided above is true and accurate.

Patient/Guardian Signature: _____ Date: _____