Registration Form

Date: _____

DX Code: _____
Therapist: _____

Patient Information

Patient Name (Print): _____ Date of Birth: _____
(Last Name) (First Name) (Initial)

Street Address: _____ Home Phone: _____

City: _____ State: _____ _____ Zip: _____ Work Phone: _____

Soc. Sec. #: _____
Phone: _____ Emergency Contact: _____ Emerg

Sex: Female Male Relationship Status: Single Married Widowed Divorced Separated Partnered

Age: _____ _____ Referred By:

_____ May we
acknowledge this referral? _____

_____

Primary Insurance

Primary Insurance Company: _____ Phone: _____

Ins Claims Address: City: State: Zip: _____
Employer: Occupation: _____

_____

Policy Holder Information (if the patient is not the employee/policy holder)

Name: _____ Date of Birth: _____
(Last Name) (First Name) (Initial)

Address: City: _____ State: Zip: Relationship:

Policy/Member ID: Group/Account #: _____

_____ _____ _____

_____

Secondary Insurance

Secondary Insurance Company: _____ Phone: _____

Ins Claims Address: City: State: Zip: _____
Soc. Sec. #: _____ Employer: _____

Policy/Member _____ ID: Group/Account #:

_____

Policy Holder Information (if the patient is not the employee/policy holder)

Name: _____ Date of Birth: _____
(Last Name) (First Name) (Initial)

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

_____ Relationship: _____

Soc. _____ Sec. #: Employer: _____

_____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name: _____ Relationship: _____

_____

Address: _____ Phone:

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship to Patient Date