

**PATIENT REGISTRATION**

Please fill in ALL the blanks.

Last Name		First Name		Date of Birth	Sex (M/F)	Age
Home Address		City		State	ZipCode	
Mailing Address ( If different )						
E-mail address		Home Phone		Work Phone		Cell Phone
Social Security Number			Driver's License No.			
Employer's Name		Occupation		Employer's Phone		
Employer's Address		City		State	ZipCode	
Are you employed ( circle one ) Full time Part time Retired Not Employed				Marital Status ( circle one ) Single Married Divorced Separated Widowed		
Whom may We thank for referring to our practice ?						
Name of Primary Physician( If different )				Primary Physician's phone		

**NOTIFY IN CASE OF EMERGENCY**

Name		Relationship				
Address		City		State	ZipCode	
Home Phone		Work Phone		Cell Phone		

**FINANCIAL INFORMATION**

PRIMARY INSURANCE CO.			Phone			
Claims Address		City		State	ZipCode	
Subscriber Name		Subscriber Date of Birth		Subscriber SSN		
Insurance I.D. Number		Group No.		Effective Date		
SECONDARY INSURANCE CO.			Phone			
Subscriber Name		Subscriber Date of Birth		Subscriber SSN		
Insurance I.D. Number		Group No.		Effective Date		
<b>WERE YOU INJURED ON THE JOB ?</b> Yes No			Have you informed your Employer ? Yes No			
WORKER'S COMPENSATION Carrier Name			Date of Injury			
WC Carrier Claim Address		City		State	ZipCode	
Adjuster's Name		Adjuster's Phone		Fax		
WCB Case Number		WCB Authorization Number		Carrier Case Number		
<b>NO-FAULT</b> Policy holder's Name		Policy No.		Date of Accident		Claim No.
Claim Rep Name		Phone Fax		Address		

I, the undersigned have insurance coverage as stated above and assign directly to Dr. R. Patel, all medical 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 the insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

**PATIENT'S SIGNATURE:****DATE:**