Patient Registration

Patient's Name: ______________________________ **Age:** ______ **Birthdate:** ____________ Sex: M ☐ F☐

Social Security Number: __________________________ **Handedness:** R ☐ L☐ **Race:** ______________

Address: ____

Home No: ____________________ **Work No:** ____________________ **Cell No:** ____________________

Spouse's Name __________________ **Single**☐ **Married**☐ **Divorced**☐ **Widow/er**☐ **No. of Children** _____

Patient's Employer Name/Address/Phone: ____

____

Spouse Employer Name/Address/Phone: ____

____

Referring Physician: ____________________________ **Family Physician:** ____________________

Chief Complaint: ______________________ **Date Of Onset:** ______________________________

Emergency Contact (Name/Telephone) ____

Primary Insurance Information

Name of Insurance Company ____

Policy Number ______________________________ Group Number ______________________

Address: ____

Phone: ____

Name Of policy Holder ________________________ Relationship to Insured: ____________________

Insured's Date of Birth ______________________ Insured's Social Security # ____________________

Secondary Insurance Information

Name of Insurance Company: ____

Policy Number ______________________________ Group Number: ______________________

Address: ____

Phone: ____

Name Of policy Holder ________________________ Relationship to Insured: ____________________

Insured's Date of Birth: ______________________ Insured's Social Security # ____________________

Work/ Auto Related Injury

Is this the result of an accident: Auto ☐ Work☐ Date of Accident: ______________________________

Name of Insurance Company: ____

Claim Number: ____

Address: ____

Phone: ____

Name and Phone # of Adjuster handling Claim: ____

Name and Phone # of Attorney handling Claim: ____

Name: ______________________________

Date of Birth: ______________________________

Primary Care Physician: ______________________________

Pharmacy Name: ______________________________

Pharmacy Address: ______________________________

Pharmacy Phone Number: ______________________________

Medications: List all prescription and over-the-counter medications.

Medication Name	Dose (such as 2 mg, 1 tsp)	How often? {Such as 3 times a day}	Prescribing Dr. 's Name	Reason for taking medication

Allergies: List any medications or foods that you are allergic to and your reaction.

Allergies	Reaction Example: Seafood, especially shellfish. Skin rash and nausea.

PRIVACY INFORMATION

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

OK TO LEAVE INFORMATION?

	Appointment Information:	Med Info:
On home phone (Include Auto Call)?	___Yes	___Yes
On Cell Phone (Include Auto Call)?	___Yes	___Yes
On Office Voice Mail?	___Yes	___Yes
W/ another person?	___Yes	___Yes
Send via mail?	___Yes	___Yes
Send via email?	___Yes	___Yes

Email Address______________

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list their name(s), relationship(s) and phone # below:

Name:	Relationship:	Phone:	Cell Phone: