

## Patient Registration W/C

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M/ F

Single/Married/Widowed/Separated/Divorced

Driver's License # \_\_\_\_\_ State \_\_\_\_\_

Employed By \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Attorney Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Pharmacy \_\_\_\_\_

Race \_\_\_\_\_

Ethnicity \_\_\_\_\_

Preferred Language \_\_\_\_\_

Email \_\_\_\_\_

County that you Live in \_\_\_\_\_

## Worker's Compensation Information:

Referring Physician \_\_\_\_\_

Referring Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Insurance Plan \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Claim Number \_\_\_\_\_

Date of Injury \_\_\_\_\_

Job Title \_\_\_\_\_

Adjuster Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Staff Use Only:  
Accepted body parts:

- Consult
- Consult and Treat
- Secondary Treat
- 2<sup>nd</sup> Opinion

UR: \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

I hereby authorize the doctor to release all information necessary to my insurance company to process all claims incurred and to send all benefits directly to this office.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_