

PATIENT REGISTRATION FORM

PATIENT - THIS SECTION REFERS TO PATIENT ONLY

Please print and complete all information requested on this form.

<u>Name</u>	<u>Age</u>	<u>Date of Birth</u>
<u>SS No.</u>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
<u>Maiden Name</u>	<u>Address</u>	
<u>City</u>	<u>State</u>	<u>Zip Code</u>
<u>Home Phone</u>	<u>Cell Phone</u>	
<u>Employer</u>	<u>Work Phone</u>	

RESPONSIBLE PARTY-THIS SECTION REFERS TO THE PERSON RESPONSIBLE FOR PAYMENT

Check which one applies Self Patient is a minor. *See insurance information below.*

PERSON TO CONTRACT IN CASE OF EMERGENCY

<u>Name</u>	<u>Relationship</u>	<u>Phone</u>
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PRIMARY INSURANCE INFORMATION

Please check which one applies to you and complete information below. Insurance Workman's Compensation Self Pay

<u>Insurance Company's Name and Address</u>		
<u>Phone Number</u>	<u>Insured's Name (who holds insurance)</u>	<u>Insured's Date of Birth</u>
<u>Relationship to Patient</u>		
<u>HIC/Policy Number or Social Security Number</u>	<u>Group Number</u>	

WORK COMP and MVA –REQUIRED INFORMATION

<u>Case worker's name</u>	<u>Phone</u>	<u>Claim#</u>
<u>Date of Injury (REQUIRED)</u>		

SECONDARY INSURANCE INFORMATION

<u>Insurance Company's Name and Address</u>		
<u>Phone Number</u>	<u>Insured's Name (who holds insurance)</u>	<u>Insured's Date of Birth</u>
<u>Relationship to Patient</u>		
<u>HIC/Policy Number or Social Security Number</u>	<u>Group Number</u>	

ASSIGNMENT OF BENEFITS

I hereby assign to Encore Health Group any insurance or third-party benefits available for healthcare services provided to me. I understand that Encore Health Group has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Encore Health Group, I agree to forward the practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

<u>Signature of Patient / Legal Guardian</u>	<u>DATE</u>
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