Patient Registration Form

Today's date: ____________ Last name: ____________ First: ____________ Middle: ____________

Social security #: ____________ Birth date: ____/____/____ Age: ________ Sex: ☐ F ☐ M

Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Student Email address: ____________

Street address: ____________

City: ____________ State: ____________ ZIP: ____________

Home phone: *Please include area code* ( ) ____________

Cellphone: *Please include area code* ( ) ____________

Work phone: *Please include area code* ( ) ____________

Patient's employer: ____________ Occupation: ____________

Employer's address: ____________ City: ____________ State: ____________ ZIP: ____________

Spouse's name: ____________ Birth date: ___/___/___ Spouse's social security #: ____________

Spouse's employer: ____________

Spouse's business phone: *Please include area code* ( ) ____________

Occupation: ____________

Referring physician name: ____________ Primary care physician: ____________

If you were not referred by a physician, how did you hear about us? ☐ Family ☐ Yellow Pages ☐ Internet ☐ Patient ☐ Other

Is this a work-related accident? ☐ Yes ☐ No Date of injury: ____________ Employer's name: ____________

Insurance Information (Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ☐ Yes ☐ No

Please provide **Primary** insurance information

Insurance company name: ____________

Subscriber's name: ____________ Social security #: ____________ Birth date: ___/___/___

Group #: ____________ Policy #: ____________ Co-payment $ ____________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (explain) ____________

Responsible Party (If patient is under 18)

Name: ____________ Social security #: ____________ Relationship to patient: ____________

Address: ____________ City: ____________ State: ________ ZIP: ________ Home phone: ( ) ____________

Father's name: ____________ Birth date: ____________ Social security #: ____________

Employer: ____________ Address: ____________

Work phone: ( ) ____________

Mother's name: ____________ Birth date: ____________ Social security #: ____________

Employer: ____________ Address: ____________

Work phone: ( ) ____________

In Case Of Emergency

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Britt A. Thedinger, M.D., P.C., or my insurance company to release any information required to process my claims.

____________ ____________ ____________

Patient/Responsible party signature Print name Date