PATIENT REGISTRATION
Please Print

Patient Information

Full Name: _____ **Date of Birth:** _____

******Email Address****:** _____

Patient's Social Security Number: _____

Other Names Used: _____ **Sex (please circle):** Male Female

Street Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Billing Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____ **Other Phone:** _____

Marital Status (please circle): Married Divorced Widowed Single

Race (please circle) Caucasian African American Hispanic Asian Native American Other

Is the patient a US Citizen (please circle)? Yes No

Patient Work Information

Employed? (please circle) Full Time Part Time Not Working Retired (when, mm/yyyy) _____

Employer: _____

Street Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Employer Phone: _____ **Occupation:** _____

Spouse Retirement Information (Required)

Is spouse retired? No Yes (when, mm/yyyy) _____

Other Information

Next of Kin (blood relation): _____

Street Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____ **Other Phone:** _____

Relationship to Patient: _____

Emergency Information

Person to Notify in Case of Emergency (other than Next of Kin): _____

Street Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____ **Other Phone:** _____

Relationship to Patient: _____

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Accident/Injury Information

Is this a result from an accident/injury (please circle)? No Yes, **then complete this section**

Provide location and brief explanation of accident/injury? _____

_____

_____

Is this accident/injury work related (please circle)? No Yes, Date of accident/injury: _____

Supervisor: _____

Witnesses: _____

Is this accident/injury related to a motor vehicle accident (please circle)? No Yes, Date: _____

If yes, have you completed an MRA Form (please circle)? No Yes

Did this accident/injury happen at home? No Yes, Date of accident/injury: _____

Policy Holder Information (Insurance and Employment)

Social Security Number of Policy Holder: _____ **Policy Holder's Date of Birth:** _____

Name of Policy Holder: _____

Policy Holder's Race: Caucasian African American Hispanic Asian Native American Other

Is the Policy Holder a US Citizen (please circle)? Yes No

Street Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____ **Other Phone:** _____

Policy Holder's Relationship to Patient: _____

Employed? (Please Circle): Full Time Part Time Unemployed Retired (when, mm/yyyy) _____

Policy Holder's Employer: _____

Employer's Street Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Employer Phone: _____ **Occupation:** _____

Physician Information

Primary Care Physician: _____

B

Any Other Medical Providers for this medical condition? _____

Present your Photo ID and Insurance cards to the receptionist to make copies

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Past Medical History: Do you have or have you had in the past or are taking medication for:

Allergies	____ Yes	____ No	
Alzheimer's/Dementia	____ Yes	____ No	
Anxiety	____ Yes	____ No	
Arthritis/RA/OA/OP	____ Yes	____ No	
Asthma	____ Yes	____ No	
Black Lung	____ Yes	____ No	
Cancer	____ Yes	____ No	where: _____
Diabetes; Insulin Dependent	____ Yes	____ No	
Medicine Controlled	____ Yes	____ No	
Depression	____ Yes	____ No	
Heart Attack/Angina	____ Yes	____ No	
Heart Disease	____ Yes	____ No	
High Blood Pressure	____ Yes	____ No	
Hypothyroidism	____ Yes	____ No	
Kidney Failure/End Stage Dialysis	____ Yes	____ No	
Kidney Problems/Stones	____ Yes	____ No	
Kidney Transplant	____ Yes	____ No	
Muscle Disease	____ Yes	____ No	
Pacemaker	____ Yes	____ No	
Parkinson's Disease	____ Yes	____ No	
Stroke/TIA	____ Yes	____ No	
Other Medical Condition/s	____ Yes	____ No	Describe: _____
Are you pregnant at this time?	____ Yes	____ No	

Are You Receiving Home Health Services now OR OP Physical Therapy? ____ Yes ____ No

All Previous Surgeries Other Than This Condition:

_____

_____

_____

_____

Current Medicines for all Medical Conditions:

_____

_____

_____

_____

For This Condition Only:

X-Rays – Date of Test: _____ **Location of Test:** _____

MRI – Date of Test: _____ **Location of Test:** _____

CT Scan – Date of Test: _____ **Location of Test:** _____