Patient Registration Information

PATIENT'S PERSONAL INFORMATION

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Name: _____

Mailing address: _____ (Apt #_____) City: _____ State: _____ Zip: _____

Home phone: (_____)_____ Work phone: (_____)_____ Social Security # _____

Date of Birth: _____/_____/_____ Driver's License: (State & Number) _____

Spouse's Name: _____ Spouse's Work phone: (_____)_____

How do you wish to be addressed? _____

PATIENT'S / WORK RELATED INJURY

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of Injury: _____

Workers Comp Insurance Company Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Adjuster: _____ Claim #: _____ Telephone: (_____)_____

Fax: (_____)_____

Nurse Case Manager: _____ Phone: (_____)_____ Fax: (_____)_____

Employer's name: _____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

Your occupation: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY insurance company's name: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Other ☐ Child

Insurance ID number: _____ Group number: _____

SECONDARY insurance company's name: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Other ☐ Child

Insurance ID number: _____ Group number: _____

PATIENT'S REFERRAL INFORMATION

Primary Care Physician: _____

Referred By: _____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Noah D. Weiss, M.D., and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

Method of Payment: ❑ Cash ❑ Check