

Patient Registration Form

Name: _____
Last First Middle

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Birth Date: _____ Age: _____

Cell Phone: _____ E-mail: _____

Marital Status: _____ Social Security #: _____

Employer: _____ Work Phone: _____

Address: _____

Occupation: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Complete this section only if someone other than patient is financially responsible:

Responsible Party: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ DOB _____ SS#: _____

Employer: _____ Work Phone: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

This section must be completed:

Areas for treatment: _____ Right _____ Left _____

Is your visit due to an injury? Yes or No

Describe Injury: _____

Date of Injury: _____

Did your injury occur on the job? Yes or No

If yes, did you report the injury to your employer? Yes or No

Is your injury the result of an auto accident? Yes or No

Did your injury occur at a residence? Yes or No

Insurance

Name: _____
Last First Middle

Patient Relationship to the Insured: (circle one of the following)

- | | |
|--|----------------------|
| 01=Patient is the insured | 08=Employee |
| 02=Spouse | 13=Grandchild |
| 03=Natural Child/ Insured is financially responsible | 14=Niece/Nephew |
| 04=Natural Child/ Insured is not financially responsible | 18=Parent |
| 05=Step Child | 19=Grandparent |
| 06=Foster Child | 29=Significant Other |
| 21=Adopted Child | 36=Emancipated Minor |
| 10=Handicapped Dependent | 53=Life Partner |
| 16=Sponsored Dependent | G8=Other Relation |
| 17=Minor Dependent of a Minor Dependent | |

(Primary Insurance)

Name of Insurance Company: _____
Policyholder's Name: _____
Policyholder's Birth Date: _____ Policyholder's SS #: _____
Policyholder's Employer: _____
Policy ID Number: _____ Group Number: _____

(Secondary Insurance)

Name of Insurance Company: _____
Policyholder's Name: _____
Policyholder's Birth Date: _____ Policyholder's SS #: _____
Policyholder's Employer: _____
Policy ID Number: _____ Group Number: _____

Assignment of Benefits/HIPAA Release: I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to disclose for the permitted uses, including disclosures via fax. I also authorize payment of medical and surgical benefits to Paul V. Spiegl, M.D.

Signature: _____ Date: _____
(Patient or Responsible Party)