

PATIENT REGISTRATION / INFORMATION



DOCTOR: _____

Name: _____ Birthdate: _____

Soc. Sec.#: _____ - _____ - _____ Driver/s License #: _____ Age: _____ Sex: M F

Address: _____ Telephone: (____) _____

City, State, Zip: _____ Marital Status: _____

E-Mail Address: _____ Cell Phone:(____) _____

Referring Physician: _____

Patient's Employer: _____

Address: _____ Telephone: (____) _____

City, State, Zip: _____ Occupation: _____

Were you injured at work? Yes No If yes, how? _____

SPOUSE / PARENT INFORMATION (Please Circle Spouse or Parent)

Name: _____ Birthdate: _____

Soc. Sec.#: _____ - _____ - _____ Sex: M F

Address: _____ Telephone: (____) _____

City, State, Zip: _____ Marital Status: _____

Employer: _____

Address: _____ Telephone: (____) _____

City, State, Zip: _____ Occupation: _____

In Case of Emergency Contact:

Name: _____ Telephone: (____) _____

PRIMARY INSURANCE CARRIER

Ins. Name: _____ Telephone: (____) _____

Address: _____ City, State, Zip: _____

Insured's Name: _____

Soc. Sec.#: _____ - _____ - _____ DOB: _____

SECONDARY INSURANCE CARRIER

Ins. Name: _____ Telephone: (____) _____

Address: _____ City, State, Zip: _____

Insured's Name: _____

Soc. Sec.#: _____ - _____ - _____ DOB: _____

I authorize the holder of medical or other information to release to my insurance carrier, governmental agency, or its intermediary, any information needed for this or a related insurance claim. I agree to pay any charges incurred by me to ETMC Physicians Clinic.

I AUTHORIZE THE VERBAL RELEASE OF MEDICAL INFORMATION PERTAINING TO MY HEALTH TO THE FOLLOWING:

If no one (✓ here)

List Person or Persons: _____

SIGNATURE OF PATIENT (PARENT IF PATIENT IS A MINOR)

DATE