

PATIENT REGISTRATION FORM

DATE: _____

Please **PRINT LEGIBLY** and make sure you complete all information on this form. Upon completion, please give to the Front Desk Receptionist with your Insurance Card(s) and Photo Id.

LAST NAME		FIRST NAME		MIDDLE NAME	NICKNAME
DATE OF BIRTH		GENDER		SOCIAL SECURITY NUMBER	
/ /		<input type="checkbox"/> Male <input type="checkbox"/> Female		- -	
VOCATIONAL CATEGORY – EMPLOYMENT INFORMATION					
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Homemaker <input type="checkbox"/> Disability <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired					
DRIVERS LICENSE NUMBER		MARITAL STATUS (check one)			LANGUAGE
		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other			
HOME PHONE		WORK PHONE		CELL PHONE	
() -		() -		() -	
HOME ADDRESS			CITY	STATE	ZIP CODE
EMPLOYER					
EMPLOYER ADDRESS			CITY	STATE	ZIP

INSURANCE INFORMATION					
Are you currently staying in a Nursing Facility (Temporary or Permanently)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a Worker's Compensation Claim? (check one)				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your condition a result of an accident from employment?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your condition a result of an auto accident?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your condition a result of any other type of accident?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Accident / /					

PRIMARY INSURANCE COMPANY					
BILLING ADDRESS			CITY	STATE	ZIP
PHONE NUMBER		ID#	GROUP #	PLAN #	
() -					
INSURED'S NAME			INSURED'S DATE OF BIRTH	RELATIONSHIP TO PATIENT	
			/ /	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other	

SUPPLEMENTAL INSURANCE COMPANY					
BILLING ADDRESS			CITY	STATE	ZIP
PHONE NUMBER		ID#	GROUP #	PLAN #	
() -					
INSURED'S NAME			INSURED'S DATE OF BIRTH	RELATIONSHIP TO PATIENT	
			/ /	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other	

The above information is true to the best of my knowledge. I understand that I am financially responsible for supplies and services received.

Signature: _____

Date: _____

INTERNAL OFFICE USE ONLY

- | | | |
|--------------------------|--|--|
| <input type="checkbox"/> | Demographics Complete | Patient Information / General Info Tab |
| <input type="checkbox"/> | Scan Patient Identification | Patient Information / General Info Tab |
| <input type="checkbox"/> | Medical History | Medical HX / Administrative Documents |
| <input type="checkbox"/> | Patient Consent & Acknowledgement Form Received & Scanned to Admin Documents | HIPAA Docs & Supplier Standards / Administrative Documents |
| <input type="checkbox"/> | HIPAA Signatures Received / Recorded | HIPAA Docs & Supplier Standards / Administrative Documents |
| <input type="checkbox"/> | Supplier Standards Signature Received / Recorded | HIPAA Docs & Supplier Standards / Administrative Documents |
| <input type="checkbox"/> | Scan Patient Intake Documents | Scanned Documents Form / Administrative Documents Folder |
| <input type="checkbox"/> | Start Up Prescription Received & Scanned | Patient Information / Prescriptions Tab |
| <input type="checkbox"/> | Detailed Prescription Submitted to Referring Physician | Detailed Prescription / Initial Evaluation |
| <input type="checkbox"/> | Diabetic Verification Submitted to Primary Care Physician | Diabetic Verification Form / Initial Evaluation |
| <input type="checkbox"/> | Insurance Verification Completed | Insurance Ver v3.0 / Administrative Documents |
| <input type="checkbox"/> | Insurance Authorization Completed | Insurance Auth v2.0 / Administrative Documents |
| <input type="checkbox"/> | Service Estimate Created | Service Estimate / Administrative Documents |
| <input type="checkbox"/> | Financial Responsibility / Counseling Completed | Financial Responsibility / Administrative Documents |
| <input type="checkbox"/> | Release Orders in Purchasing System | OPIE Lite & FAB Tracking |