PATIENT REGISTRATION INFORMATION

Patient's Full Name: _____

Mailing Address: _____ Date of Birth: _____

_____ Social Security #: _____

City: _____ Zip: _____ Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married

Home Phone: _____ Cell Phone: _____

Referred to this office by: _____

Employer's Name and Address: _____

Work Phone: _____ Occupation: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Not employed

IS YOUR TREATMENT TODAY RELATED TO AN INJURY OR WORK-RELATED INCIDENT? ☐ YES ☐ NO

COMPLETE THIS SECTION ONLY IF TREATMENT IS INJURY OR WORK-RELATED

Date of Incident/Injury: _____ SSN or Claim #: _____

Bill to (insurance carrier) name & address: _____

_____

HEALTH INSURANCE INFORMATION (Please present all cards, copies are required)

Primary Health Insurance Company: _____

Policy Subscriber: _____ Date of Birth: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent

Contract / Policy #: _____ Group #: _____

ASSIGNMENT, AUTHORIZATION & RELEASE

I hereby assign, transfer, and authorize payment of medical benefits to be paid to Carolyn Alaimo, Ph.D. for services provided. I also authorize the release of any information, to billing agents, insurance carriers, and other responsible parties, as necessary in order to process claims and obtain reimbursement. I understand that I am financially responsible for all charges whether or not they are covered by insurance. This authorization shall remain valid until I give written notice revoking said authorization.

Patient's Signature _____ Date _____

To be completed by provider:

Primary Diagnosis/Condition: _____ Date: _____