



Patient Registration Form

2105 E Clairemont Avenue, Eau Claire, WI 54701 (715) 835-9514 Fax (715) 835-2602

Please complete following information, write N/A if not applicable

Patient Information

First _____ MI _____ Last _____ Gender: Male Female

Address _____ City _____ State _____ Zip _____

Social Security # _____ Date of Birth ____/____/____ Age _____ How did you hear about us? _____

Marital Status: Single Married Widowed Divorced Separated Spouse's Name _____

Phone: Home (____) _____ Fax (____) _____ Email Address _____

Work (____) _____ Occupation _____ Employer _____

Employer Address _____ City _____ State _____ Zip _____

Please check any and all insurance coverage you have and/or the method of payment applicable, and complete all pertinent information.

Cash Medicare Medicaid Health Insurance Other Auto Accident Worker's Compensation

If you are a full-time student, please fill out parent's information in PRIMARY GUARANTOR boxes!

Primary Guarantor

First _____ MI _____ Last _____

Address _____

City _____ State _____ Zip _____

Soc Sec # _____ Date of Birth ____/____/____ Male Female

Home Phone (____) _____ Work (____) _____

Employer _____

Address _____

City _____ State _____ Zip _____

PRIMARY INSURANCE

Insurance Co _____

Address _____

City _____ State _____ Zip _____

Group Name _____

Group/Plan# _____

Insured's ID# _____

Patient's Relationship to Insured:
 Self Spouse Child Other

Secondary Guarantor

First _____ MI _____ Last _____

Address _____

City _____ State _____ Zip _____

Soc Sec # _____ Date of Birth ____/____/____ Male Female

Home Phone (____) _____ Work (____) _____

Employer _____

Address _____

City _____ State _____ Zip _____

SECONDARY INSURANCE

Insurance Co _____

Address _____

City _____ State _____ Zip _____

Group Name _____

Group/Plan# _____

Insured's ID# _____

Patient's Relationship to Insured:
 Self Spouse Child Other

ASSIGNMENT, AUTHORIZATION AND POLICY STATEMENT

I believe that all information is complete to the best of my knowledge. I will be responsible for any expenses the insurance carrier does not meet. I fully understand and agree that the insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are my responsibility. I hereby assign the benefits I am eligible to receive for the care rendered in this office. I authorize the office to release any information, to any insurance company, adjuster or attorney that will assist in payment of claims. A photocopy of this form will be considered as valid as the original.

Date _____ Patient _____ Resp Party _____ CA _____

For AUTO ACCIDENT or WORKER'S COMP CLAIMS, please continue on reverse side of form.

Please fill out the following portion if you were involved in an AUTO ACCIDENT.

All information must be completed in order to process your claim. **If you do not have this information, please call our business office within 5 days. Please provide us with a copy of the police report by your next visit.**

YOUR INSURANCE INFORMATION

Your Auto Insurance Co. _____
 Address _____
 Phone # _____
 Insured's Name _____
 Address _____
 Phone # _____
 Insured's Date of Birth ____/____/____ Male Female
 Patient's Relationship to Insured: Self Spouse Child Other
 Policy # _____ Claim # _____
 Agent/Adjuster _____
 Address _____
 Phone # _____
 Have you retained an attorney? No Yes
 Attorney's Name _____
 Attorney's Address _____
 Phone # _____

OTHER DRIVER'S INSURANCE INFORMATION

Other Insurance Carrier _____
 Address _____
 Phone # _____
 Insured's/Driver's Name _____
 Address _____
 Phone # _____
 Insured's Date of Birth ____/____/____ Male Female
 Patient's Relationship to Insured: Self Spouse Child Other
 Policy # _____ Claim # _____
 Agent/Adjuster _____
 Address _____
 Phone # _____

Please continue on with Yellow Personal Injury Questionnaire

Please fill out the following portion if you were involved in an injury sustained at WORK.

According to Wisconsin State Laws. An injury sustained at work is NOT covered by Worker's Compensation until the Employer's Insurance Company has ACCEPTED LIABILITY for the claim. Therefore, the employee is responsible for all charges incurred where Liability is not accepted. Please make sure your injury has been reported to your Employer and that they have reported the injury to their Liability Insurance Company.

I have read and understand the above statement re: WI WorkCompLaws: _____
 Patient's Signature Date

Please continue on with the Green Worker's Comp History Information form.

In Office Use Only

Entered By	Verified By	NP/OP	Dx Entered	WL	RL