PATIENT REGISTRATION

Patient Name____
Last First Middle Initial (Nickname)

Home Address____
Street Apt. #

____
City State Zip

Home Phone (   ) __________________ **Cell Phone (   )** ____________________
Area Code Area Code

Emergency Contact____________________ **Emergency Phone (   )** ________________

Male ( ) Female ( ) Body part being evaluated______________________________

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widow/er

Birth date: ___/___/_____ Age: ______ Social Security # __________________________

E-Mail ____

Primary Care Physician: ___________________________ **Phone # (   )**________________

Referred by (Dr./Patient/Friend): ____

Referred By Attorney?_______________________________ **Phone # (   )**______________

Patient's Employer/School:__________________________ **Phone # (   )** _____________

BILLING INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Ins. Co. Name: ________________________	Ins. Co. Name:__________________________
Subscriber Name: _____________________	Subscriber Name: _______________________
Date of Birth: __________________________	Date of Birth: ___________________________
Policy #:_______________________________	Policy #:________________________________
Group #: ______________________________	Group #: ________________________________
Employer: _____________________________	Employer: _______________________________

Does your insurance carrier require a referral? ( ) Yes ( ) No
Is this a labor and industries claim? ( ) Yes ( ) No

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished me by any of the physicians of EOC. I authorize any holder of medical information about me to release to HCFA and its agents or to my insurance any information needed to determine these benefits. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, and I accept financial responsibility for non-covered services.

______________________________________ ______________________
Signature **Date**

Turn Over

E·O·C
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NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practice** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature | Date | Time

____ ______________________________

Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative)

This area for staff notes (if any):

This form will be retained in your medical record

11/05