



Welcome to ProHEALTH Care Associates, LLP.

PATIENT REGISTRATION FORM

In order to serve you, we need the following information. Please print.

| | | | | | | |
|---|--|--|---------|--|----------------------|---|
| Today's Date: | | Thank you for selecting ProHEALTH Care Associates. | | | | |
| PATIENT INFORMATION | | | | | | |
| Patient's Last Name: | | First: | Middle: | Gender: | Age: | Birth Date: |
| Social Security No.: | | Preferred Language: | | Marital Status: S M D W SEP | | Student: <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time |
| Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American | | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Two or More Races | | <input type="checkbox"/> Decline to Answer | | Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to Answer |
| Street Address: | | City/Town: | | State: | Zip Code: | Home Phone No.: |
| Mobile Phone No.: | | Email Address: | | | Work No.: | |
| Name of Employer: | | Address: | | City/Town: | | State: Zip Code: |
| SPOUSE'S INFORMATION | | | | | | |
| Last Name: | | First: | Middle: | Gender: | Age: | Birth Date: |
| Mobile Phone No.: | | Work No.: | | | Social Security No.: | |
| Employer: | | Street Address: | | City/Town: | | State: Zip Code: |
| PARENT INFORMATION | | | | | | |
| Complete the section below with your parent's information if you are a full time student covered under their health insurance. | | | | | | |
| Insured's Last Name: | | Insured's First: | Middle: | Gender: | Age: | Birth Date: |
| Mobile Phone No.: | | Work No.: | | | Social Security No.: | |
| Employer: | | Street Address: | | City/Town: | | State: Zip Code: |
| EMERGENCY CONTACT | | | | | | |
| Name of Relative or Local Friend (not living at same address): | | | | Relationship to Patient: | | |
| Primary Telephone No.: | | | | Secondary Telephone No.: | | |
| PRIMARY CARE PHYSICIAN | | | | REFERRING PHYSICIAN | | |
| Primary Care Physician Name: | | | | Referring Physician (if not same as PCP): | | |
| Street Address: | | | | Street Address: | | |
| City, State, Zip: | | Telephone No.: | | City, State, Zip: | | Telephone No.: |
| Please provide the name/s and telephone numbers of any other doctors treating you at this time. | | | | | | |
| PHARMACY INFORMATION | | | | | | |
| Name of Pharmacy: | | Address: | | | Telephone No.: | Fax No.: |

HEALTH INSURANCE INFORMATIONPatient's Relationship to Insured: Self Spouse Child Other:

Insurance Name:

Claims Address:

Telephone No.:

Group No.:

ID No.:

Insured's Name (if not self, spouse or parent listed above):

Insured's S.S. No.:

Birth Date:

**PRIMARY
INSURANCE**Patient's Relationship to Insured: Self Spouse Child Other:

Insurance Name:

Claims Address:

Telephone No.:

Group No.:

ID No.:

Insured's Name (if not self, spouse or parent listed above):

Insured's S.S. No.:

Birth Date:

**SECONDARY
INSURANCE****WORKER'S COMPENSATION INFORMATION****Is the reason for this visit due to a work related accident?** Yes No **If yes, you must complete this section.**

Date of Injury/Onset of Illness:

Employers Insurance Carrier Name & Address:

WCB Case No.:

Carrier Case No.:

Are you currently working? Yes No

Last Day Worked:

Briefly describe how and where patient's injury occurred:

NO FAULT INFORMATION**Is the reason for this visit due to a motor vehicle accident?** Yes No **If yes, you must complete this section.**

Date of Accident:

Insurance Carrier Name:

Address:

Policyholder's Name:

Policy No.:

Claim No.:

Relationship to Insured: Self Spouse Other:

Claims Adjuster:

Telephone No.:

Are you currently working? Yes No

Last Day Worked:

Briefly describe how and where patient's injury occurred:

ATTORNEY INFORMATION

Law Firm Name:

Address:

Name of Attorney Handling Case:

Telephone No.:

Fax No.:

AUTHORIZATION FOR RELEASE OF INFORMATION BY ProHEALTH Care Associates, LLP

I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize ProHEALTH Care Associates, LLP to furnish all records and results to the parties I specify.

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____**ASSIGNMENT OF BENEFITS**

I hereby assign, transfer and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical costs of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____

