

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.
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PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Gender:	Age:	Birth Date:
Marital Status: S M D W SEP	Preferred Language:				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"/> 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:	Apt #	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.:				
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.:				
Employer:	Street Address:		City/Town:	State:	Zip Code:

EMERGENCY CONTACT

Name:	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:	City, State, Zip:
Telephone No.:	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.:
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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):

Birth Date:

PRIMARY
INSURANCEPatient'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):

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.:

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