DIAGNOSIS AND TREATMENT PLAN/ PHYSICAL EVALUATION/ TREATMENT MODIFICATIONS

REGISTRATION

TODAY'S DATE ________________ DATE OF BIRTH __________________

PATIENT'S NAME __________________________________SOCIAL SECURITY NUMBER ________________

NAME OF SPOUSE __________________________________SOCIAL SECURITY NUMBER ________________

IF A CHILD, PARENT NAME ____

CIRCLE ONE: SINGLE WIDOWED MARRIED DIVORCED SEPARATED

ADDRESS (If P. O. BOX PLEASE PROVIDE PHYSICAL ADDRESS AS WELL)

____ **P: Home** ________________**Cell:** ________________

CITY________________________ **STATE** _______ **ZIP**________________

PATIENT EMPLOYED BY ____ PHONE ___________________

CITY __________________ STATE/ ZIP _______________

PRESENT POSITION ___________________________ HOW LONG HELD ______

SPOUSE EMPLOYED BY ____ PHONE ___________________

CITY__________________STATE/ZIP_________________

PRESENT POSITION ___________________________ HOW LONG HELD _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? ____

ADDRESS ________________________________CITY__________________ STATE/ZIP ________________

PHONE ______________________ RELATION TO PATIENT __________________

WHO WILL PAY THIS ACCOUNT? ______________________________RELATION TO PATIENT: ____________

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES: YES NO

(Please present Insurance card to our staff if one is available.)

NAME OF COMPANY: _______________________GROUP # ______________ I.D. # ____________

NAME OF INSURANCE CARD HOLDER ___________________________ **SS #** _________________

DOB______________________

WHOM MAY WE THANK FOR REFERRING YOU? ____

COMMENTS:

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