Eastside Sports Rehabilitation Clinic

Patient Registration

PLEASE PRINT

Personal Information

Patient Name _____ Mr. Ms. Miss Mrs.
Last First Middle

Address _____

_____
City State Zip

Birth Date _____

Soc. Sec. # _____

Marital Status ____Single ____Married ____Other

Emergency Contact (*Nearest friend or relative not living with you):*

Name: _____ Phone: _____ Relationship: _____

Today's Date: _____

Home Phone (_____) _____-_____

Work Phone (_____) _____-_____

Mobile Phone (_____) _____-_____

Email _____

We prefer billing by email. Please indicate if interested: _____ Yes _____ No

We also accept electronic payments.

Nature of Injury/Symptom

Whom may we thank for referring you to this office? _____

Primary Care Physician _____

Date of Onset or Injury_____ Body Part Involved _____*right or left*

Cause of Injury _____

Billing Information

Patient's Occupation _____

Patient's Employer _____

Employer's Address_____

_____

Spouse's Name _____

Spouse's Employer _____

Spouse's Phone _____

If Other than Patient, Insurance Subscriber Information:

Subscriber Name _____

Address _____

_____

Home Phone _____

Work Phone _____

Subscriber's Birth Date _____

Patient Relationship to Insured _____

WE MUST HAVE A COPY OF YOUR INSURANCE CARD ON FILE

Please complete the following as it applies to you:

Did your injury happen at work? ____ Yes _____ No

Date of Accident _____ Employer at time of Injury _____

Insurance Company _____ Claim Number _____

Insurance Address _____Insurance Phone _____

Were you involved in a motor vehicle accident? _____ Yes _____ No

Date of Accident _____ Insurance Company Name _____

Claim Number _____ Insurance Address _____

Ins Co. Phone _____ Attorney Phone _____

Attorney Name _____ Are they currently paying on your claim? _____

PLEASE MAKE SURE YOU HAVE ANSWERED <u>ALL</u> THE ABOVE QUESTIONS

Assignment and Release: I hereby assign to Eastside Sports Rehabilitation Clinics, PLLC ("ESRC") any and all benefits from any insurer, third party or other protection maintained for my benefit, and authorize and direct that such benefits be paid directly to ESRC for services provided by ESRC. I also authorize the release of any of my health information to any person or entity that is or may be responsible for payment for services rendered by ESRC, including without limitation, insurers and third party payers. I understand that, regardless of insurance coverage, I am responsible for the balance of my account. All accounts are due and payable within 30 days. If I do not pay the balance in full within 30 days of the monthly billing date a finance charge will be added to the account of 1% per month which is an annual percentage rate of 12%. The above information is complete and accurate to the best of my knowledge and I understand and accept the information above.

_____ _____ _____

Signature of Patient *(or patient's authorized representative)*

Relationship/ Status if signed by anyone other than the patient (e.g. parent, legal guardian, personal representative)

Date