

Please complete and fax to 480-513-4867, or bring with you to your visit.

(Last) \_\_\_\_\_

**PATIENT REGISTRATION**

PATIENT Name: (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  M  F

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Spouse/Guardian Name: (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

Spouse/Guardian Date of Birth: \_\_\_\_\_ Spouse/Guardian SSN: \_\_\_\_\_

Spouse/Guardian Employer: \_\_\_\_\_ Spouse/Guardian Employer Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

PRIMARY Insurance Co. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured Relationship to Patient: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ Insured ID/Claim #: \_\_\_\_\_ Group #: \_\_\_\_\_

SECONDARY Insurance Co. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured Relationship to Patient: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ Insured ID/Claim #: \_\_\_\_\_ Group #: \_\_\_\_\_

Please circle if this condition resulted from any of the following:    Work Injury    Motor Vehicle Accident    Other Accident\*

Please list the date of injury: \_\_\_\_\_ \* If Other Accident please specify: \_\_\_\_\_

Is there currently a claim or lawsuit open or pending regarding this injury?    YES    NO

If yes, please provide the name and phone number to your attorney: \_\_\_\_\_

Who shall we call in an Emergency? \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

I fully understand and agree that my signature authorizes payment to be made directly to Back In Action and I further authorize release of any and all medical records or other pertinent information necessary to obtain payment. I understand and agree that I am ultimately responsible to ensure that all services needing pre-authorization by my insurance company are pre-authorized and that any balances for denied services, deductibles, coinsurance and copays are my responsibility to pay.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

