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:

Street Address:	City/Town:	State:	Zip Code:

Social Security No.:	Marital Status: S M D W SEP	Home Phone No.:	Student: ☐ Part Time ☐ Full Time

Mobile Phone No.:	Email Address:
Employer:	Business Address:

Work No.:	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 if you are a full time student covered under your parents' health insurance.

Last Name:	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

Primary Care Physician Name:	
Street Address:	
City, State, Zip:	Telephone No.:

REFERRING PHYSICIAN

Referring Physician (if not same as PCP):	
Street Address:	
City, State, Zip:	Telephone No.:

PHARMACY INFORMATION

Name of Pharmacy:	Address:	Telephone No.:
		Fax No.:

INSURANCE INFORMATION

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

PRIMARY INSURANCE

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:

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

SECONDARY INSURANCE

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:

WORKERS 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:	Employer's 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:** _____/_____/_____