Robertson Spinal Rehab Associates
Out of injury, back to life

Patient Registration Information

Please print and complete all sections below.

Account #_____

Is your condition a result of a **work injury**? YES NO **Auto accident**? YES NO Date of Injury:_____

Patient Personal Information Marital Status:_____Single _____Married _____Divorced _____Widow Sex: ____M ____F

Name:_____ _____ _____
(Last Name) (First Name) (Initial)

Street Address:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Mailing Address (if different from street address):_____

City:_____ State:_____ Zip:_____

Primary Phone: (_____) _____-_____ Secondary Phone: (_____) _____-_____

Employer:_____ Work Phone: (_____) _____-_____

Date of Birth:_____/_____/_____ Age:_____ E-Mail Address: _____

Spouse's Name:_____ Spouse's Work Phone:(_____) _____-_____

Driver's License: (State & Number):_____ How do you wish to be addressed?_____

Patient's / Responsible Party Information

Responsible Party:_____ Date of Birth:_____/_____/_____

Relationship to Patient: _____Self _____Spouse _____Other_____

Responsible party's Home phone:(_____) _____-_____ Work Phone:(_____) _____-_____

Responsible party's Employer's Name:_____

Street Address:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Patient's Insurance Information **Please present insurance card to receptionist**

PRIMARY Insurance Company's Name:_____

Insurance Address:_____ Apt/Ste #:_____

City:_____ State:_____ Zip:_____

Name of Insured:_____ Date of Birth:_____/_____/_____

Relation ship to Insured:_____Self _____Spouse _____Child _____Other_____

Insurance ID #:_____Group #:_____

*****Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any co-insurance, deductible amount or any other balance not paid for by your insurance.***** _____ **Patient's Initials**

OVER ☞

Patient's Referral Information

Referred by:_____ If referred by a friend, may we thank them?____Yes ____No

Name (s) of other physician (s) who care for you:_____

_____

_____

Emergency Contact Information

Name of person not living with you:_____ Relationship:_____

Street Address:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Primary Phone: (_____) _____-_____ Secondary Phone: (_____) _____-_____

Assignment of Benefits ● Financial Agreement

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses and attorney fees incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Date:_____/_____/_____ Your Signature:_____

Method of Payment: _____Cash _____Check _____Credit Card _____Debit Card

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