### Advanced Rehab & Wellness Center, PC

# REGISTRATION FORM

|  |
| --- |
| **(Please Print)** |
| PATIENT INFORMATION |
| Patient’s last name: | First: | Middle: |
|  |  |  |
| ❑ Mr. ❑ Mrs. ❑ Miss  ❑ Ms. ❑ Dr.  | ❑ Single ❑ Married ❑ Divorced  ❑ Separated ❑ Widowed | Birth date: / / | Age: | ❑ Male ❑Female  |
| Spouse’s Name | Children: ❑ No ❑ Yes  | # \_\_\_\_ | Other family membersseen here: |  |
| Street address: | Social Security #: | Home Phone: |
|  |  -- -- | ( ) |
| City: | State: | Zip Code | Cell Phone: |
|  |  |  | ( ) |
| Occupation: | Employer: | Work Address: | Work Phone: |
|  |  |  | ( ) |
| Referred by (name) | ❑ Dr.  |  |
| Email Address: |  |
|  |
| INSURANCE INFORMATION |
| Person responsible for bill: | Birth date: | Address (if different): | Home Phone : |
|  | / / |  | ( ) |
| Occupation: | Employer: | Work Address: | Work Phone: |
|  |  |  | ( ) |
| Insurance Co: | Insured’s SS #: | Group #: | Policy #: |
|  |  - - |   |  |
| Patient’s relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other | Co-pay/Co-insurance = $ |
| Name of secondary insurance (if applicable): | Insured’s name: | Group #: | Policy #: |
|  |  |  |  |
| Patient’s relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other | Insured’s SS# | Co-pay $ |
|  |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ABC Billing, LLC or insurance company to release any information required to process my claims. |
| Patient/Guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| For Office Use Only |
| **Diagnosis** |
|  |  |  |  |  |
|  |  |  |  |  |
| Provider | Signature | Date |