### 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 members  seen 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 | | | | |