

# Pacific Handworks

## PATIENT REGISTRATION FORM

Patient Name: \_\_\_\_\_  
Last First M.I.

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex:  F:  M:  Soc.Sec. #: \_\_\_\_\_

Patient's Parent or Spouse: \_\_\_\_\_ Soc.Sec. #: \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ PCP: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Cause: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_ Cause: \_\_\_\_\_

Was this an ON THE JOB INJURY?  Y:  N:  If so, CLAIM #: \_\_\_\_\_

Was this an AUTO ACCIDENT?  Y:  N:  If so, CLAIM #: \_\_\_\_\_

Insured Company: \_\_\_\_\_ Address: \_\_\_\_\_

Adjustor's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient's Relationship to Insured: Self:  Spouse:  Dependent:  Other:

Secondary Insurance Carrier: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient's Relationship to Insured: Self:  Spouse:  Dependent:  Other:

In Case of Emergency, Call: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to Pacific Handworks Inc., P.S. and I am financially responsible for non-covered services. I also authorize the release of any information required to process insurance.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_