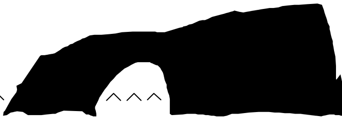

PATIENT REGISTRATION INFORMATION
Please PRINT and complete ALL sections below!

PATIENT Name: ______________________________
Last First M.I.

Birthdate: ______________ Age:______ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: ______________ City: ______________ State: ______ Zip: ______________

Home Phone: ( ) ______________ Cell Phone: ( ) ______________

Social Security: ______________ Driver's License (State & Number): ______________

Employer: ______________ Work Phone: ( ) ______________

Medical Reason For Visit: ______________________________

Referred By: ______________ Primary Physician: ______________

Date of Onset/Injury: ______________ Work-Related Injury? ☐ Yes ☐ No

Spouse Name: ______________ Work Phone: ( ) ______________

Emergency Contact: ______________ Phone: ( ) ______________

PARENT/GUARDIAN Name: ______________ Birthdate: ______________

Social Security: ______________ Relationship to Patient: ☐spouse ☐parent ☐other: ______________

Employer: ______________ Work Phone: ( ) ______________

INSURANCE INFORMATION ***Please complete ALL insurance information. A copy of your insurance card is required.***

Primary Insurance: ______________ Secondary Insurance: ______________

Ins. Address: ______________ Ins. Address: ______________

City: ______________ State: ______ Zip: ______________ City: ______________ State: ______ Zip: ______________

Name of Insured: ______________ Name of Insured: ______________

Employer: ______________ Employer: ______________

ID Number: ______________ ID Number: ______________

Group Number: ______________ Group Number: ______________

Rel. to Patient: ☐ self ☐ spouse ☐parent ☐other: ______________ Rel. to Patient: ☐ self ☐ spouse ☐ parent ☐ other: ______________

Insured's Birth Date: ______________ Insured's Birth Date: ______________

I DIRECTLY ASSIGN ALL MEDICAL/SURGICAL BENEFITS TO DR. HANTKE (MY PHYSICIAN), AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE MY PHYSICIAN TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. FURTHERMORE, I AUTHORIZE MY PHYSICIAN, OR HIS REPRESENTATIVES, TO OBTAIN COPIES OF ANY AND/OR ALL CLINICAL RECORDS RELEVANT TO THE PURSUIT OF THE ISSUE(S) FOR WHICH I AM BEING SEEN IN THIS OFFICE. I UNDERSTAND THAT ALL RETURNED CHECKS MAY BE SUBJECT TO A SERVICE CHARGE AND THAT I MAY BE RESPONSIBLE FOR OTHER COSTS OF COLLECTION AS PERMITTED BY LAW. I UNDERSTAND THAT, ULTIMATELY, THE RESPONSIBILITY FOR ADHERING TO THE RECOMMENDED TREATMENT AND FOLLOW-UP PLAN RESTS WITH ME, AND THAT THIS RESPONSIBILITY SPECIFICALLY SHALL REMAIN, NOTWITHSTANDING THE PRESENCE OR ABSENCE OF INSURANCE APPROVAL FOR THE SAME. WITH MY SIGNATURE BELOW, I GIVE MY GENERAL CONSENT TO RECEIVE SUCH TREATMENT AND/OR DIAGNOSTIC MEASURES THAT MAY BE DEEMED NECESSARY BY MY PHYSICIAN.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE.

Method of Payment: ☐ cash ☐ check ☐ credit card

Signature of Responsible Party: ______________________________ Date: ______________