Adient Health

PATIENT REGISTRATION SHEET

Appt date _____ **Therapist Name** _____ **Patient Acct #** _____ **DX** _____

PATIENT INFORMATION

Patient Name: _____ Sex: M F DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Marital Status: S M D W DriversLic # _____

Cell Phone: _____

Employer Name: _____ Employment Status FT PT Student FT PT

Employer Address: _____ City: _____ State: _____ Zip: _____

Work Phone: **RETIRED DATE (if applicable)**

Spouse, Parent, or Legal Guardian

Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer Name: _____ Employment Status: FT PT Student: FT PT

Employer Address: _____ City: _____ State: _____ Zip: _____

Work Phone: **RETIRED DATE (if applicable)**

Responsible for Payment ☐ Self ☐ Spouse ☐ Other _____

Emergency Contact Person _____ Relationship _____ Phone _____

Referring Physician:

INSURANCE INFORMATION (Please complete this section for Health Ins. Coverage)

Primary Ins _____ Address: _____

ID# / Policy# _____ Group # _____ Phone: _____

Name of Insured: _____ DOB: _____ Relationship (to patient) _____

Employer: _____

Secondary Ins _____ Address: _____

ID# /Policy # _____ Group# _____ Phone: _____

Name of Insured: _____ DOB _____ Relationship (to patient) _____

Employer:

WORK COMP INFO. (Please complete this section only if this is a work related injury)

Work Comp Ins. _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Adjuster: _____

Date of Injury: _____ Details: _____ Claim #:

FOR OFFICE USE ONLY

Precert/Auth required? _____ % Insurance pays _____ Patient Copay _____

Deductible Amt _____ Deductible Met _____ Pre-Exisiting clause? _____

Visits allowed per year? _____ $ Amount allowed per year? _____

Visits allowed per Injury _____ $ Allowed per injury _____

Out Of Pocket Per Year? _____ Out Of Pocket Paid to date: _____

Comments _____

Verified by Date