PATIENT REGISTRATION

Proactive Alternatives, PC

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Patient Name *(Last, First, M.I.):* ☐ M ☐ F		DOB	AGE
Home Address	CITY	STATE	ZIP
Home Phone	PERSONAL CELL	BUSINESS PHONE	
Patient's Social Security	**Driver's License No.**		
Email Address			
Patient's Marital status ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Whom May We Thank for Referring You to Our Practice?	**Today's Date:**		

EMPLOYER INFORMATION

Employer	OCCUPATION:		
Address	CITY	STATE	ZIP
Business Phone	☐ Full Time ☐ Part Time		

EMERGENCY NOTIFICATION

Emergency Contact	RELATIONSHIP:		
Address	CITY	STATE	ZIP
Home Phone	CELL		

FINANCIAL INFORMATION – PRIMARY INSURANCE

Name *(Person responsible for fees):*	PHONE:		
Address	CITY	STATE	ZIP
Insurance Company	INSURANCE ID#		
Claim Address	CITY	STATE	ZIP
Subscriber's Name	SUBSCRIBERS DATE OF BIRTH	SUBSCRIBERS SSN#	

FINANCIAL INFORMATION – SECONDARY INSURANCE

Name *(Person responsible for fees):*		PHONE:	
Address	CITY	STATE	ZIP
Insurance Company	INSURANCE ID#		
Claim Address	CITY	STATE	ZIP
Subscriber's Name	SUBSCRIBERS DATE OF BIRTH	SUBSCRIBERS SSN#	

MEDICAL AND LEGAL INFORMATION

Were you Injured on the Job?	☐ YES ☐ NO		
Have you Informed Your Employer?	☐ YES ☐ NO		
Date of Injury	WORKERS COMPENSATION CARRIER NAME		
Address	CITY	STATE	ZIP

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Proactive Alternatives, P.C., all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such practitioner and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the practitioner to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such practitioner and clinic any and all plan documents, insurance policy and/or settlement information, any and all service determination information, and all information I am entitled to receive under ERISA upon written request from such practitioner and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named practitioner and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named practitioner and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such practitioner and clinic in any attempts by such practitioner and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such practitioner and clinic against such insurers and/or employee health care plan in my name but at such practitioner and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian

Date