426A McCall Road . Manhattan, KS 66502 . 785/776-0670
4201B Anderson Ave, Suite 1 . Manhattan, KS 66503 . 785/539-5555

PATIENT REGISTRATION

Patient Name ___________________________________ Date of Birth ______________ Age _________

Address ____ City _____________________ State _________

Zip Code ____________ Phone # (Home) _______________ (Cell) _______________ (Work) _______________

Email Address ____SSN ____

Employer ____________________________________ Employer Address ____________________________________

What is the best way to contact you? **CELL___ HOME PHONE___ EMAIL___**

What time of day works best to contact you? **MORNING___ AFTERNOON____EVENING___**

Who is responsible for patient's medical expenses? ____

Relationship to patient ___________________ **Please bring your insurance card or cards.**

Policyholder: ____________________ Policyholder date of birth: ___________________

Address if different than the patient's ____

Insurance Company __________________________ ID# ____________________ Group# ______________

Employer ____ Home Phone ________________________________

Cell Phone ___________________________ ___ Work Phone ____

Person to call in an emergency ____

Referring Physician_____________________________ Body part to be treated _________________________

Is this visit due to an accident/injury? Yes____ No____ If yes, date of injury___________________________

Was it work related? Yes____ No____ Brief Description of Accident_____________________________________

____

If workman's compensation, has accident been reported to employer? Yes____ No ____

Employer Name ________________________________ Address_____________________________________

Supervisor's Name _____________________________ Phone # ______________________________________

Send claims to ____

Auto Accident? Yes____ No_____ Liability Insurance Company ___________________________________

Address _______________________________________ Phone # ______________________________________

Agent's Name __________________________________ Claim # ______________________________________