



426 A McCall Rd · Manhattan, KS 66502 · 785-776-0670 · MPPT@max.kscoxmail.com

PATIENT REGISTRATION

Patient Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____

Zip Code _____

Phone # (Home) _____ (Cell) _____ (Work) _____

Employer _____ SSN _____

Employer address _____ Email 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 # _____

