Allied Health Solutions, LLC

REGISTRATION FORM

(**PLEASE PRINT**)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Sex:	Marital status
Street Address					
City:			State:	ZIP Code:	
Home Phone:	Cell Phone	Work Phone	Email:		
Date of Birth	Age:	Social Security #:	Emergency Contact Name:	Emergency Contact Tel #	
Is this Accident Related ? ☐ Yes ☐ No	Select ☐ Auto ☐ WC ☐ Other	Location of Injury/Accident ☐ VA ☐ DC ☐ MD ☐ Other	Date of Injury / Accident:		
Referring Physician:	Tel#	Fax #			

Health Insurance

Subscriber 's Name:	Date of birth:	Social Security #:	Relationship to Patient:
Primary Insurance:	Policy #:	Group:	Tel #
Secondary Insurance:	Policy #:	Group:	Tel #

Workman's Compensation

Employer Name & Address:		Employer Tel #	Employment Status:
Insurance Name & Address :			Tel #
Adjustor / Case Manager Name	Claim# :		Tel #
Was Injury Reported Supervisor: ☐ Yes ☐ No	Date Reported	Supervisor Name:	Tel #

Auto mobile Accident

Auto Insurance / Med Pay or Lien Company Tel #		Claim #
Auto Insurance / Lien Company Tel #		Adjuster Name Tel #:
Attorney Name:	Phone #:	Fax#

PRINT NAME
Patient/Parent or Guardian

Signature
Patient/Parent or Guardian

Date