

REGISTRATION FORM- J.T.S.

Golconda

Last Name: _____ Initial: _____ First Name: _____

Street _____ City _____ State _____ Zip _____

Maiden Name: _____ Previous Address: _____

E-mail address: _____

Home Phone: _____ Work Phone: _____ Cell# _____

Employer: _____ Phone: _____

Birthdate: _____ Age: _____ Social Security: _____ Sex: _____

Referring Physician: _____ Next M.D. Appt: _____

Responsible For Medical Expenses	
Parent _____ Spouse _____ Self _____	Work Accident _____ Auto Accident _____
Name: _____	Attorney: _____
Address: _____	Address: _____
SS#: _____	Atty Phone: _____
Date of Birth: _____	Police Report Copy: Yes No
Employer: _____	Auto Ins Co: _____
Employer Phone: _____	Ins Phone: _____

Medicare #: _____ Medicaid #: _____

Primary Ins: _____ Group#: _____ ID#: _____

Name of Subscriber: _____ Phone# _____

Secondary Ins: _____ Group#: _____ ID#: _____

Name of Subscriber: _____ Phone# _____

Emergency contact: _____ Relationship: _____ Phone: _____

Brief Description of Incident: _____

Have you had an: MRI CT-scan X'ray Other _____

Brief History/Medications: _____

Pregnant? Yes No High Blood Pressure? Yes No Cancer? Yes No

How did you hear about us? M.D. Advertisement Friend Internet Other

Insurance Authorization and Assignment

I hereby authorize treatment of the patient named above and agree to pay all fees and charges for services rendered. I authorize Joyner Therapy Services to submit billing and furnish information to insurance carriers concerning the illness and treatment of the patient named above. I hereby assign all payments from insurance carriers to be paid directly to Joyner Therapy Services for all medical services rendered.

Notice of Privacy Practices

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices of J.T.S..

Name (Print)

Patient Signature

Date

Responsible Party Signature Relationship