near ✱ site
work health solutions

REGISTRATION - PATIENT INFORMATION

Name ______________________ Date of Birth___/___/___ Age_____
Address ______________________
City______________________ State______________ Zip______________
Home Phone ______ ______________ Work Phone ______ ______________
Email ______________________ Sex: ☐Male ☐Female
Social Security Number______________________ Marital Status: ☐M ☐S ☐W ☐D

REFERRAL INFORMATION

How did you find Med Care Medical Center?

☐ Employer ☐ Location ☐ Internet Search (Google, etc.) ☐ Other ______________
☐ Relative ☐ Friend ☐ Yellow Pages ☐ Dr. ______________

GUARANTOR INFORMATION

Responsible Party (if a minor)______________________
Address ______________________ City______________________
State______________ Zip________ Home Phone ______ ______________
Relationship to Patient______________________ Social Security Number______________________

INSURANCE INFORMATION

Name of Insurance Company______________________
Subscribers Name______________________ Date of Birth___/___/___
Subscribers Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other______________
ID Number______________________ Group Number______________________
Claims Address______________________
City______________________ State______________ Zip______________
Home Phone ______ ______________ Work Phone ______ ______________
I have secondary insurance coverage ☐ No ☐ Yes If yes, Insurance Company______________

WORKERS COMPENSATION INFORMATION

Industrial Insurance Carrier ______________________
Address ______________________
City______________________ State______________ Zip______________
Employer at time of injury______________________ Date of Injury______________

AUTHORIZATION

I, the undersigned, consent to medical care rendered by Work Health Solutions. I hereby authorize release of any information necessary to process this claim and authorize benefits to be paid directly to Work Health Solutions. Health insurance is becoming very complex with varying and changing insurance companies and plans. Ultimately, it is the patient's responsibility to pay for services provided by Work Health Solutions.

Signature ______________________ Date ______________