Case/Occupational Medicine Registration Form

PATIENT INFORMATION

IDX Account #: ____________ Date: ____________

Patient's Last Name: ____________ Social Security Number: ____________

First Name: ____________ MI ____ Date of Birth: ____________ Sex: ☐ M ☐ F

Address: ____________ Home Phone: (____) ____________

City, State, Zip: ____________

CASE INFORMATION

Type of Case: ☐ Auto ☐Workman's Comp ☐ Occupational Medicine ☐ Legal ☐ Contract☐ Donor ☐Other

If Occupational Medicine: Package #: ____________

Date of Accident/Injury: ____________ If Auto, State of Accident: ____________

Description of Injury or Type of Contract: ____________

Insured's Name: ____________ Relationship to Patient: ____________

Liability Insurance Name: ____________ Claim #: ____________

Liability Insurance Address: ____________

Adjustor Name: ____________ Adjuster Phone #: (____) ____________

Liability Policy #: ____________

****Liability information is used to send the medical bills to the area responsible to pay for medical services for example auto insurance, pre employment physicals etc.****

PRIMARY HEALTH INSURANCE

Insurance Company Name: ____________ Effective Date: ____________

Address: ____________

Insured Party's Last Name: ____________ Social Security Number: ____________

First Name: ____________ MI ____ Date of Birth: ____________ Sex: ☐ M ☐ F

Insured's Address: ____________ Relationship to Patient: ____________

City, State, Zip: ____________ Patient's ID#: ____________

Group #: ____________ Co-Payment Amount: ____________

*****Please present motor vehicle insurance ID card and health insurance card to the Front Desk*****