ProHEALTH℠ Care

Welcome to ProHEALTH Care Associates, LLP.

PATIENT REGISTRATION FORM

In order to serve you, we need the following information. Please print.

Today's Date:	**Thank you for selecting ProHEALTH Care Associates.**

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Gender:	Age:	Birth Date:

Marital Status: S M D W SEP	Preferred Language:	Student: ☐ Part Time ☐ Full Time

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White ☐ Black or African American ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Street Address:	Apt #	City/Town:	State:	Zip Code:	Home Phone No.:

Mobile Phone No.:	Email Address:	Work No.:

Name of Employer:	Address:	City/Town:	State:	Zip Code:

SPOUSE'S INFORMATION

Last Name:	First:	Middle:	Gender:	Age:	Birth Date:

Mobile Phone No.:	Work No.:

Employer:	Street Address:	City/Town:	State:	Zip Code:

PARENT INFORMATION

Complete the section below with your parent's information if you are a full time student covered under their health insurance.

Insured's Last Name:	Insured's First:	Middle:	Gender:	Age:	Birth Date:

Mobile Phone No.:	Work No.:

Employer:	Street Address:	City/Town:	State:	Zip Code:

EMERGENCY CONTACT

Name:	Relationship to Patient:

Primary Telephone No.:	Secondary Telephone No.:

PRIMARY CARE PHYSICIAN

Primary Care Physician Name:	

Street Address:	

City, State, Zip:	Telephone No.:

REFERRING PHYSICIAN

Referring Physician (if not same as PCP):	

Street Address:	

City, State, Zip:	Telephone No.:

Please provide the name/s and telephone numbers of any other doctors treating you at this time.

PHARMACY INFORMATION

Name of Pharmacy:	Address:	Telephone No.:	Fax No.:

HEALTH INSURANCE INFORMATION

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

PRIMARY INSURANCE

Insurance Name:	Claims Address:	Telephone No.:	Group No.:
			ID No.:
Insured's Name (if not self, spouse or parent listed above):			Birth Date:

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

SECONDARY INSURANCE

Insurance Name:	Claims Address:	Telephone No.:	Group No.:
			ID No.:
Insured's Name (if not self, spouse or parent listed above):			Birth Date:

WORKER'S COMPENSATION INFORMATION

Is the reason for this visit due to a work related accident? ☐ Yes ☐ No **If yes, you must complete this section.**

Date of Injury/Onset of Illness:	Employers Insurance Carrier Name & Address:
WCB Case No.:	Carrier Case No.:
Are you currently working? ☐ Yes ☐ No	Last Day Worked:

Briefly describe how and where patient's injury occurred:

NO FAULT INFORMATION

Is the reason for this visit due to a motor vehicle accident? ☐ Yes ☐ No **If yes, you must complete this section.**

Date of Accident:	Insurance Carrier Name:	Address:
Policyholder's Name:	Policy No.:	Claim No.:
Relationship to Insured: ☐ Self ☐ Spouse ☐ Other:	Claims Adjuster:	Telephone No.:
Are you currently working? ☐ Yes ☐ No	Last Day Worked:	

Briefly describe how and where patient's injury occurred:

ATTORNEY INFORMATION

Law Firm Name:	Address:	Name of Attorney Handling Case:	Telephone No.:
			Fax No.:

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____