

Body Sage Massage Therapies PATIENT REGISTRATION FORM

(Please Print)

Today's Date: _____

PATIENT INFORMATION

Patient's Last Name:		First:	MI:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status (circle one) Single / Mar / Div / Other	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name):		Birth Date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:			Social Security #:		Home Phone #: ()		
P.O. Box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer Phone #: ()		
Chose Body Sage Massage Therapies because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							
Date of Injury:		First Dr. Appt.		Did you miss any work?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
				If 'Yes', how many days?:			
Are you taking any medications?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, please indicate what kind:				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:		Birth Date: / /	Address (if different):		Home Phone #: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Auto	<input type="checkbox"/> Workers Comp.	<input type="checkbox"/> Health	<input type="checkbox"/> Other: _____		
<i>If Workers Comp. employer's name at the time of injury:</i>							
Insurance Company Name:		Policy Group/FECA#:		Insurance Plan/Program Name			
Name of Insured:		SS/ID #:	Insured's DOB: / /	Co-Payment: \$	Claim Rep:	Claim Rep Phone:	
Address:							
P.O. Box:		City:		State:		ZIP Code:	
Claim #:		No. of Authorized Visits:		Prior Authorization #:			
Name of Secondary Insurance (if applicable):			Name of Insured:		Group #:		Policy #:
Patient's Relationship to Insured:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY

Emergency Contact Name:		Relationship to patient:	Home Phone #: ()	Work Phone #: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Body Sage Massage Therapies or insurance company to release any information required to process my claims.

Patient/Guardian signature Date