THE STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION Today's Date_____

Patient Name _____
Last First (Legal) Middle Initial Nickname

Date of Birth _____ Age_____ SS# _____ Sex M ☐ F ☐

Race_____Ethnicity_____Language_____

Cell Phone _____ Work Phone _____ Home phone _____

Permanent mailing address _____

City _____State _____ Zip_____

Email address _____ Occupation _____

Marital Status _____Spouses Full Name _____ Phone _____

Contact In Case of Emergency _____

Relationship _____ Phone _____

Primary Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

How were you referred to us?

Medical Professional ☐ Family / Friend ☐ Internet/Website ☐ Other ☐ _____

Referral Name _____ City / State / Zip _____

INJURY INFORMATION

Date of injury _____ Work Related: NO ☐ YES ☐ Auto Accident: NO ☐ YES ☐

What is injured? _____

Describe Injury _____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

Carrier_____ Address _____

City_____ State_____ Zip_____ Phone _____

Policy ID Number_____ Group _____

Name of the Policy Holder_____ Relationship _____

Address_____ City_____ State_____ Zip _____

Date of Birth_____ Social Security Number _____ Sex M F

Employer_____ Occupation _____

SECONDARY INSURANCE COMPANY:

Carrier_____ Address_____

City_____ State_____ Zip_____ Phone _____

Policy ID Number_____ Group _____

Name of the Policy Holder_____ Relationship _____

Address_____ City_____ State_____ Zip _____

Date of Birth_____ Social Security Number _____ Sex M F

Employer_____ Occupation _____

WORKMAN'S COMPENSATION INSURANCE:

Carrier_____ Address _____

City_____ State_____ Zip_____ Phone _____

Claim Number_____ Case Worker's Name _____

Case Worker's Phone Number_____ Fax _____

Employer at Time of Injury _____

Address _____

Patient _____ Date _____

Responsible Party _____ Date _____

UNACCOMPANIED MINOR WAIVER

This section is required to be signed by a parent or legal guardian in order for an unaccompanied minor to be seen by any physician or clinical staff at The Steadman Clinic. By signing, you (parent/guardian) agree that The Steadman Clinic may evaluate and treat the unaccompanied minor in whatever way is medically necessary.

Parent/Guardian Signature: _____ ***Date:*** _____

Nondiscrimination

The Steadman Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

This information available in Spanish upon request. Solicite la versión en español de esta información.