MIDWEST HEALTH CARE NETWORK

☐ Midwest Sports Medicine
☐ The Center for Physical Therapy
☐ Open MRI Imaging Specialists
☐ Midwest Center for Pain Management

REGISTRATION INFORMATION

I. INJURY / EMERGENCY CONTACT

Part of Body Affected:______________________ Date of Injury:__________
Who referred you to this office?______________ Who is your primary Dr.?______________
Address:______________________ Phone: ( ) __________
In case of Emergency who should be notified?______________________
Phone:( ) ______________ Relationship:______________

II. PATIENT INFORMATION

Social Security No.:______________
Legal Name:______________ Age:________ Date of Birth:________
Sex: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Address:______________ City:__________ State:______ Zip:________
Home Phone:__________ Cell Phone:__________ Work Phone:__________
Driver's License No.:______________ Employer's/School Name:______________
Employer's/School Address______________ City:__________ State:______ Zip:________

III. GUARANTOR INFORMATION *(If different from Patient)*

Legal Name:______________ Age:________ Date of Birth:________
Sex: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Address:______________ City:__________ State:______ Zip:________
Home Phone:__________ Cell Phone:__________ Social Security No.:__________
Driver's License No.:______________ Employer's Name:______________
Employer's Address:______________ City:__________ State:______ Zip:________

IV. PRIMARY INSURANCE INFORMATION

Name of Ins. Co.:______________ Policy ID No.:______________
Group No.:__________ Phone No.:__________ Co-Payment: $______ Referral Needed: ☐ YES ☐ NO
If different than patient, fill in below:
Name of Policyholder:______________ Date of Birth:______________
Address:______________ City:__________ State:______ Zip:________
Social Security No.:______________ Employer:______________

V. SECONDARY INSURANCE INFORMATION

Name of Ins. Co.:______________ Policy ID No.:______________
Group No.:__________ Phone No.:__________ Co-Payment: $______ Referral Needed: ☐ YES ☐ NO
If different than patient, fill in below:
Name of Policyholder:______________ Date of Birth:______________
Address:______________ City: __________ State:______ Zip:________
Social Security No.:______________ Employer:______________

VI. WORKER'S COMPENSATION OR LEGAL/ACCIDENT (If applicable)

Name of Carrier:______________________
Address:______________ City:__________ State:______ Zip:________
Phone No.:__________ Claim No.:__________ Name of Adjuster:__________
Employer at Time of Accident:______________ Phone No.:__________
Name of Attorney:______________ Phone No.:__________
Verification of W/C: ☐ YES ☐ NO Date Made:__________ by:______________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent, have insurance coverage and assign directly to Midwest Health Care Network and its affiliates, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the use of my health care information and such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining services and determining insurance benefits or the benefits payable for related services. This consent will end upon termination of coverage with the above-named Insurance Company(ies) or one year from the date signed below.

______________________ Signature of Patient, Parent, Guardian or Personal Representative

______________________ Please print name or Patient, Parent, Guardian or Personal Representative

__________ Date

__________ Relationship to Patient

Account No.__________
(For Office Use Only)

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