LAURA DAHMER-WHITE, PH.D.
PATIENT REGISTRATION FORM

PATIENT INFORMATION Date: _____

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: Home: _____ Cell: _____ Work: _____ Okay to call? ☐

Employer: _____ Occupation: _____

Name of Spouse / Partner: _____

Person to contact in emergency: _____ Phone #: _____

PERSON RESPONSIBLE FOR PAYMENT OR INSURANCE (IF NOT PATIENT)

Name: _____ Relationship to patient: _____

Billing Address: _____ Phone: _____

Employer: _____ Date of Birth: _____

INSURANCE INFORMATION (Complete and provide insurance card to copy)

Is condition the result of an accident?: ☐ Yes ☐ No Date of Injury: _____

If work related, L & I Claim #: _____ Name of Case Manager: _____

If related to auto accident, name of Auto Insurance: _____

Claim #: _____ Claims Manager: _____

Address of Auto Insurance: _____

Name of Medical Insurance: _____

Insurance Address: _____

Subscriber: _____ Relationship to patient: _____

Group #: _____ ID #: _____

Do you have a referral from your primary physician?: ☐ Yes ☐ No

Name of primary physician: _____ Phone #: _____

Are you currently involved in litigation related to the present problems? ☐ Yes ☐ No

Name of your attorney: _____ Phone: _____

Who referred you to this office? _____