



**Patient Registration Form**

Chillicothe Peoria (North) Morton MedPointe Morton Village Courts Pekin Washington

Patient#: \_\_\_\_\_ Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_ Sex: M or F

Address: \_\_\_\_\_  
Street City State Zip

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Marital Status: single married widow(er) divorced

Employer's name and address: \_\_\_\_\_

**INSURANCE INFORMATION:**

Type of claim:  Health Insurance  Workers' Comp  Personal Injury (Motor Vehicle)

Type of injury/problem: \_\_\_\_\_ Date of injury: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_ ID/Claim#: \_\_\_\_\_

Group name or #: \_\_\_\_\_ Insured's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to insured: Self Spouse Son Daughter

Do you have an attorney on this claim:  No  Yes, Name and phone: \_\_\_\_\_

Where do we send the bill? \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION:** Company: \_\_\_\_\_

Address: \_\_\_\_\_

Group name or #: \_\_\_\_\_ ID#: \_\_\_\_\_ Insured's name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to insured: Self Spouse Son Daughter

<p><b>FOR OFFICE STAFF ONLY:</b> body part to be treated: _____</p> <p>Dx: _____ Onset: _____</p> <p>Other Dx: _____ if Medicare Cap Exempt? YES or NO</p> <p>Doctor: _____ Therapist: _____</p> <p>Medicare: <input type="checkbox"/>CPT II 1100F: 2 or more falls in the past year or any fall with injury in the past year  <input type="checkbox"/>CPT II 1101F: No falls in past year or only one fall without injury in the past year</p>
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