# Patient Registration Form

## Patient Information:

Full Name: Jane A. Doe

Date of Birth (MM/DD/YYYY): 06/15/1985

Gender: Female

Social Security Number: 123-45-6789

Address: 123 Main Street

City: Springfield State: IL Zip Code: 62704

Phone Number: (217) 555-7890

Email Address: janedoe@email.com

Marital Status: Single

Employment Status: Employed

Employer Name (if applicable): ABC Corporation

Emergency Contact Name: John Doe

Relationship to Patient: Brother

Emergency Contact Phone: (217) 555-1234

## Insurance Information:

Primary Insurance Provider: Illinois Workers’ Compensation Board

Policy Number: ILWC-202504-001

Group Number: N/A

Insurance Phone Number: (800) 555-WCIL

Policyholder Name: Jane A. Doe

Policyholder Date of Birth (MM/DD/YYYY): 06/15/1985

Patient’s Relationship to Policyholder: Self

Secondary Insurance Provider (if applicable): N/A

Secondary Policy Number: N/A

## Medical Provider Information:

Referring Physician Name: Dr. Emily Carter

NPI Number: 1234567890

Facility Name: Springfield Medical Center

Facility Address: 456 Health Ave, Springfield, IL 62704

Facility Phone Number: (217) 555-9876

Tax ID or EIN (if required): 12-3456789

## Authorization and Consent:

I certify that the information provided above is true and correct to the best of my knowledge. I authorize the release of medical information necessary to process my insurance claims. I also authorize payment of medical benefits to the provider for services rendered.

Patient Signature: Jane A. Doe Date: 02/25/2025

## For Office Use Only:

Patient ID Number: 001234567

Date of Service: 02/25/2025

Insurance Verified: Yes

Copay Collected: No Amount: $0.00

CPT Code: 99213

Diagnosis Code: S61.409A

Amount Charged: $150.00

Staff Initials:

Note: This is a Workers' Compensation case. No copay is required. Charges for evaluation and treatment should be submitted in accordance with WC guidelines. Estimated service charge: $350.00 (to be itemized on CMS-1500).