Macy O&P LLC
Custom Care with you in Mind

Registration Form

PATIENT INFORMATION

First name:_____ Last name:_____

DOB:_____ Social Security Number:_____ Gender: ❑Male ❑Female

Primary phone:_____ ❑home ❑mobile ❑work

Secondary phone:_____ ❑home ❑mobile ❑work

I authorize Macy O&P to leave a voice message regarding my care on the following phone number _____

I authorize Macy O&P to leave a text message regarding my care on the following phone number _____

Email address:_____

Residential Address:_____ City_____ State_____ Zip Code_____

Occupation:_____

Guarantor:_____ Phone:_____

Relationship to the patient:_____

Power of attorney: ❑ Yes ❑ No

I authorize Macy O&P to share information regarding treatment or payment for treatment, with the following individual(s): _____ _____

(Name) (Relationship)

_____ _____

(Name) (Relationship)

PHYSICIAN INFORMATION

Referring physician:_____ Phone#:_____

Date of last office visit:_____

Primary Care Physician:_____ Phone#:_____

Date of last office visit:_____

INSURANCE INFORMATION

Primary Insurance:_____ Policy#:_____

Subscriber:_____ Relationship:_____ DOB:_____

Secondary Insurance:_____ Policy#:_____

Subscriber:_____ Relationship:_____ DOB:_____

Tertiary Insurance:_____ Policy#:_____

Subscriber:_____ Relationship:_____ DOB:_____

Is your condition related to a work or automobile injury? ❑Yes ❑No

If yes, please complete the information below.

Date of Injury:_____ Claim number:_____

Adjuster's name:_____ Adjuster's phone:_____

Employer at the time of injury:_____

By signing below, you certify that all the information you have provided to us on this form is correct, complete and true to the best of your knowledge.

Patient Signature:_____ Date:_____

Signature of Personal Representative: _____ Date:_____