ELKHART CLINIC
303 South Nappanee Street
Elkhart IN 46514
574-296-3200
Fax 574-296-3921

Pre-Registration Form

Patient Data:

Account No. _____

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Social Security No. _____ Circle One: Male Female

Address _____ Apt _____ City _____

State _____ Zip Code _____ Home No. _____ Work No. _____

Employer _____ School _____

Name of Emergency/Alternate Contact _____

Relation _____ Home No. _____ Work No. _____

Marital Status: Married Single Widowed Divorced

Insurance Data (Primary):

Name of Insured (First Name, Middle Initial, Last Name) _____

Date of Birth _____ Social Security No. _____Circle One: Male Female

Address _____Apt _____ City _____

State _____ Zip Code _____ Home No. _____ Work No. _____

Employer _____ School _____

Relation to Patient _____Marital Status: Married Single Widowed Divorced

Name of Insurance Company _____

Address _____ Apt _____ City _____

State _____ Zip Code _____Network/PPO Name _____

Telephone No. _____ Fax No. _____

Identification No. _____ Group No._____

Policy Effective Date _____ Termination Date _____

Type of Coverage: Individual Family Other (Please specify) _____

Pre-existing Clause _____

Outpatient Deductible _____ Deductible Met _____ Maximum _____

Co-payment Primary Care Physician _____ Specialist _____

Physical Therapy Number of Treatments Authorized _____ Authorization No. _____

Copy of Evaluation Report to Insurance: Yes No Date _____

Occupational Therapy Number of Treatments Authorized _____ Authorization No. _____

Copy of Evaluation Report to Insurance: Yes No Date _____

Referral Referral Required: Yes No If Yes, Referral No. _____

Primary Care Physician _____ Office Telephone No. _____

Out of Network Benefits _____

Other Limits _____

Name of Representative From Insurance Carrier Providing the Information _____

Insurance Data (Secondary):

Name of Insured (First Name, Middle Initial, Last Name) _____

Date of Birth _____ Social Security No. _____ Circle One: Male Female

Address _____Apt _____City _____

State _____Zip Code _____ Home No. _____ Work No. _____

Employer _____ School _____

Relation to Patient _____ Marital Status: Married Single Widowed Divorced

Name of Insurance Company _____

Address _____ City _____

State _____ Zip Code _____ Network/PPO Name _____

Telephone No. _____Fax No. _____

Identification No. _____ Group No. _____

Policy Effective Date _____ Termination Date _____

Type of Coverage: Individual Family Other (Please specify) _____

Pre-existing Clause _____

Outpatient Deductible _____ Deductible Met _____ Maximum _____

Co-payment Primary Care Physician _____ Specialist _____

Physical Therapy Number of Treatments Authorized _____ Authorization No. _____

Copy of Evaluation Report to Insurance: Yes No Date _____

Occupational Therapy Number of Treatments Authorized _____ Authorization No. _____

Copy of Evaluation Report to Insurance: Yes No Date _____

Referral Referral Required: Yes No If Yes, Referral No. _____

Primary Care Physician _____ Office Telephone No. _____

Out of Network Benefits _____

Other Limits _____

Name of Representative From Insurance Carrier Providing the Information _____

Completed by _____ Date _____