



**PATIENT REGISTRATION FORM**

**HELIX Deerfield Beach**

750 S. Federal Highway  
Deerfield Beach, FL 33441  
P: 954-421-8181 • F: 954-426-2967

**HELIX Lake Worth**

2311 10th Avenue N.  
Lake Worth, FL 33461  
P: 561-540-4446 • F: 561-540-4430

**HELIX Tequesta**

1 Main Street  
Tequesta, FL 33469  
P: 561-747-4464 • F: 561-747-5598

**REASON FOR TODAY'S VISIT:**

**DATE:** \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> Medical Care (List Complaint) _____ | <input type="checkbox"/> Pre-Op Physical     |
| <input type="checkbox"/> Auto Accident                       | <input type="checkbox"/> Work Related Injury |
| <input type="checkbox"/> School Physical                     | <input type="checkbox"/> Work Physical       |
| <input type="checkbox"/> Vaccine/Immunization                | <input type="checkbox"/> Other: _____        |

**PATIENT INFORMATION**

- |  |                                 |
|--|---------------------------------|
| <input type="checkbox"/> NEW PATIENT         | <input type="checkbox"/> Male   |
| <input type="checkbox"/> ESTABLISHED PATIENT | <input type="checkbox"/> Female |

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Employer : \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_

*\*If under 18, please provide the following information:*

Parent/Guardian Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Parent/Guardian Address: \_\_\_\_\_  
Street: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE /CLAIM INFORMATION**

Primary Insurance: _____	Phone: _____
Policy#/ID: _____	Group#: _____
Authorization/Claim#: _____	Date of Accident: _____
Secondary Insurance: _____	Phone: _____
Policy#/ID: _____	Group#: _____

*\*If you are not the primary insured:*

Policy Holder Name: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_  
Policy Holder SS#: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Contact Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

**REFERRED BY:**

\_\_\_\_\_