

PATIENT INFORMATION

Completion of this information in its entirety is required at time of visit.

Referring Physician _____ phone # _____
Address _____
Primary Care Physician _____ phone# _____
Address _____

A. Patient Name. Legal name/as it appears on your insurance card.

First _____ Last _____ Middle _____ Marital Status _____
Birth date ____/____/____ Gender _____ Social Security # _____ - ____ - _____

Home Address _____
Street _____ City _____ State _____ Zip Code _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____ Other Phone (____) _____ - _____
Is it ok to leave a message? _____

Employer _____ Occupation _____

Employer Address _____
Street _____ City _____ State _____ Zip Code _____ Work Phone (____) _____ - _____

B. If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party _____ Address _____
Relationship to patient _____ Social Security # _____ - ____ - ____ Birth date ____/____/____
Employer _____ Address _____ Work Phone (____) _____ - _____

C. In case of EMERGENCY:

Person to contact _____ relationship _____ Phone (____) _____ - _____

D. How do you intend to pay? Cash ___ Check ___ Credit Card ___ Insurance ___ Medicare ___ Welfare ___ Other ___

Primary Insurance Co. _____ Address _____
Phone (____) _____ - _____ Policy/ID # _____ Group # _____
Subscriber Name _____ Social Security # _____ - ____ - ____ Birth date _____
Employer _____ Address _____ Work Phone (____) _____ - _____

Secondary Insurance Co. _____ Address _____
Phone (____) _____ - _____ Policy/ID # _____ Group # _____
Subscriber Name _____ Social Security # _____ - ____ - ____ Birth date _____
Employer _____ Address _____ Work Phone (____) _____ - _____

E. Reason for this visit:

Height _____ Weight _____

Date of Injury or onset of problem ____/____/____ Body Part _____
Injury Details _____

F. Please sign and return to the receptionist.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

Signature _____ Date _____