

**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. Patients Legal Name.**

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:**

Other Person to contact \_\_\_\_\_ relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

Workers' Compensation insurer's name \_\_\_\_\_ Address \_\_\_\_\_  
Date of injury \_\_\_\_/\_\_\_\_/\_\_\_\_ Claim # \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_  
Employer at time of injury \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Health 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 \_\_\_\_\_  
Accident 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 \_\_\_\_\_