PATIENT INFORMATION

PATIENT NAME: ____ DATE OF BIRTH: _______/______/_____

ADDRESS: ____CITY: __________________STATE: _______ZIP: _______

HOME PHONE: _____________________WORK PHONE: _____________________CELL PHONE: _________________

SOCIAL SECURITY#: _________________________SEX: M / F MARITAL STATUS: S M D W

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OCCUPATION: ____ EMPLOYER NAME: ______________________________

EMPLOYER ADDRESS: ____

EMERGENCY CONTACT: ________________________________RELATION: ____________________________________

HOME PHONE: ______________________________ WORK PHONE: ____________________________________

ADDRESS: ____CITY:_________________STATE:_______ZIP: __________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ____________________________________PHONE #: _________________________

POLICY HOLDER'S NAME: ____________________________________ DATE OF BIRTH: _______/_______/_______

POLICY NUMBER: _____________________________ GROUP __________________SOCIAL SECURITY # _______

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SECONDARY INSURANCE COMPANY: ________________________________PHONE #_________________________

POLICY HOLDER'S NAME: ____________________________________DATE OF BIRTH: _______/______/_______

POLICY NUMBER: _____________________________ GROUP ______________________SOCIAL SECURITY # _______

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WORKER'S COMPENSATION CLAIM? YES / NO DATE OF INJURY: ________________

COMPANY: ____

ADDRESS: ____CITY: _______________STATE: _______ZIP:__________

CONTACT PERSON: ______________________________ PHONE NUMBER: __________________________

IS THERE AN ATTORNEY INVOLVED IN YOUR CASE: YES / NO

ATTORNEY'S NAM :________________________________ PHONE: ____________________________

ADDRESS: ____CITY: _______________STATE: ________ZIP_________

IS THIS AN ACCIDENT CASE? : YES / NO VEHICLE _____ OTHER _____ DATE OF ACCIDENT _____

INSURANCE COMPANY TO BILL: _____

ADDRESS: _____CITY: _____STATE: _____ZIP: _____

PHONE NUMBER: _____ CLAIM #:_____ ADJUSTER: _____

I HEREBY AUTHORIZE PREVENTIVE AND DIAGNOSTIC MEDICAL CENTER, TO FUIRNISH INFORMATION TO THE INUSRACE CARRIERS CONCERNING MY TREATMENT AND HEREBY ASSIGN TO THE CORPORATION ALL PAYMENTS FOR SERVICES RENDERED. I UNDERSTAND HTAT I AM RESPONSIBLE FOR ALL CHARGES, EVEN THOSE NOT PAID BY MY INSURANCE. I UNDERSTAND THAT BY SIGNING I AM GIVING MY PERMISSION FOR TREATMENT, I ALSO AUTHORIZE PREVENTIVE AND DIAGNOSTIC MEDICAL CENTER TO CONTACT THE INSURANCE COMMSIONER ON MY BEHALF, TO ASSISTE ME IN RECEIVING MY FULL INUSRACE BENEFITS, IF DEEMED NECESSARY.

SIGNATURE _____ DATE: _____

SIGNATURE FOR MINOR (UNDER 18 YEARS OF AGE)_____