Date:_____ **PATIENT INFORMATION** Chart#:_____

All sections MUST be Complete. If not applicable, please indicate as "N/A"

PATIENT INFORMATION

Last Name:_____ First Name:_____ M.I._____ Nickname:_____

Sex:____ Birthdate:____/____/_____ Age:_____ SSN:_____-_____-_____ Marital Status: S M W D

Permanent Address:_____ Apt#:_____ City:_____ State:____ Zip:_____

Home:_____ Cell:_____ Work:_____

Email:_____ Employer/School Name:_____

Employed: ☐ Full Time ☐ Part Time Student: ☐ Full Time ☐ Part Time

Driver License# & State:_____ PCP/Family Physician's Name:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Pharmacy Name:_____ Phone:_____ Address:_____

Have you been treated by our physician? ☐ Yes ☐ No If Yes approximate Date:_____

Was your injury sustained on the job? ☐ Yes ☐ No

If yes, has a claim been filed with your employer? ☐ Yes ☐ No

REFERRED BY ☐ Doctor ☐ Hospital/Clinic ☐ Patient ☐ Friend/Coworker ☐ Family Member ☐ School

☐ HMO/PPO Directory ☐ Employer ☐ TV ☐ Internet ☐ Radio ☐ Print Advertising ☐ Yellow Pages

☐ Referral Service ☐ Other:_____

If referred by a physician: Last Name:_____First Name:_____Phone:_____

If referred by another source, list specific name (i.e. hospital, school, or friend)_____

PRIMARY INSURANCE (Complete with insured's information)

Insured's Name:_____

Sex:____ DOB:_____ SSN:_____

Patient Relationship to Insured_____

Employer:_____

Employer Address:_____

City:_____State:_____Zip:_____

Insurance Company:_____

Phone:_____

Claims Filing Address:_____

City:_____State:_____Zip:_____

ID#_____Group:_____

SECONDARY INS. (Complete with insured's information)

Insured's Name:_____

Sex:____ DOB:_____ SSN:_____

Patient Relationship to Insured_____

Employer:_____

Employer Address:_____

City:_____State:_____Zip:_____

Insurance Company:_____

Phone:_____

Claims Filing Address:_____

City:_____State:_____Zip:_____

ID#_____Group:_____

GUARANTOR INFORMATION (IF OTHER THAN PATIENT)

Last Name:_____ First Name:_____ M.I._____

Sex:____ Birthdate:____/____/_____ SSN:_____-_____-_____

Driver's License# & State:_____ Relationship to patient:_____

Permanent Address:_____ Apt#:_____ City:_____ State:____ Zip:_____

Home:_____ Cell:_____ Work:_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby consent to releasing information for the purposes of treatment, payment, or health care operations.

ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid directly to Kelly Cunningham MD, PA.

CONSENT FOR TREATMENT: I hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgement.

Date:_____Signature_____Relationship_____

(Patient/Parent/Guardian)