Patient information (please print)

DATE:_____

Patient Name (first/middle/last)	Social Security #	Date of Birth / /	Age	Marital Status S M W D Sep	Male ☐ Female ☐
Address	City & State	Zip Code	Home Phone ( )		
Email Address			Cell Phone ( )		
Employer		Occupation			
Employer Address	City & State	Zip Code	Business Phone ( )		

All information required if insurance is listed with a spouse as the subscriber

Spouse's Name	Spouse's Social Security #		Spouse's Date of Birth / /	
Spouse's Employer	Address	City & State	Zip	Business Phone

If patient is a minor, student or covered under a parent's insurance, please complete below:

Mother's Name	Mother's Social Security #		Mother's Date of Birth	
Mother's Employer	Address	City & State	Zip	Business Phone
Father's Name	Father's Social Security #		Father's Date of Birth	
Father's Employer	Address	City & State	Zip	Business Phone
If divorced or separated, spouse's address			Spouse's Phone	

If injured at school, list school:

If Injured playing a sport, list sport:

Name of Family Doctor:	Name of Referring Doctor:

Emergency Contact:	Phone: ( )	Relationship:

PLEASE COMPLETE INSURANCE INFORMATION ON BACK SIDE ↺

Please select an insurance:

☐ **MEDICAL**

Primary _____

ID #_____ Group #_____

Name of subscriber to insurance: _____

Date of birth of subscriber: _____

Secondary _____

ID #_____ Group #_____

Name of subscriber to insurance: _____

Date of birth of subscriber: _____

☐ **WORK COMP**

Were you hurt at work? YES NO DATE OF INJURY_____

Employer:_____

Employer Address:_____

Employer Phone #_____

Employer contact person:_____

Work Comp Insurance:_____

Claim Number:_____

Claim representative's name: _____

☐ **AUTO** **DATE OF ACCIDENT:** _____

Name of insurance:_____

Policy # _____

Claim # _____

Claim representative's name:_____

LEGAL Is there a lawyer involved with your injury YES NO

If yes: Name & Address of attorney:

_____

- ✓ I authorize use of this information on all my insurance submissions.
- ✓ I authorize release of information to all my insurance companies.
- ✓ I authorize my Medicare and Medigap insurer (if applicable) to pay claims directly to my provider.
- ✓ I authorize any holder of medical information about me to release to the Centers for Medicare (if applicable) and its agents any information needed to determine benefits payable for related services.
- ✓ I authorize any holder of Medicare information to release to my Medigap Insurer (if applicable) any information needed to determine benefits payable for related services.
- ✓ I understand that I am responsible for my bill.
- ✓ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- ✓ I authorize payment directly to my doctor.
- ✓ I permit a copy of this authorization to be used in place of the original.
- ✓ I have received or been offered a copy of the "Notice of Privacy Practices".

_____ _____

SIGNATURE PATIENT/ GUARDIAN DATE