

PLEASE FILL OUT THIS FORM COMPLETELY  
AND SIGN WHERE INDICATED - PLEASE PRINT (PRESS HARD)

Date \_\_\_\_\_

NAME OF PATIENT \_\_\_\_\_  
LAST NAME FIRST INITIAL NICKNAME

ADDRESS: \_\_\_\_\_  
STREET CITY ZIP CODE

DATE OF BIRTH \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
MONTH DAY YEAR

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SS# \_\_\_\_\_ SEX MALE  FEMALE  MARRIED  DIVORCED   
(Check One) SINGLE  SEPARATED  WIDOWED

YOUR PRIMARY PHYSICIAN \_\_\_\_\_ WHO IS RESPONSIBLE FOR PAYMENT \_\_\_\_\_

SPOUSE, PARENT OR GUARDIAN

NAME \_\_\_\_\_  
LAST NAME FIRST INITIAL NICKNAME

ADDRESS: \_\_\_\_\_  
STREET CITY ZIP CODE

OCCUPATION: \_\_\_\_\_ EMPLOYER \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WHO REFERRED THE PATIENT TO US - PLEASE PRINT NAME BELOW

REFERRING DOCTOR'S NAME REFERRING PERSON'S NAME / RELATIONSHIP / PHONE #

Have you or any member of your family been seen here before? \_\_\_\_\_ Who \_\_\_\_\_

Name of nearest relative *not* living with patient or close friend.

Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_

How Related? \_\_\_\_\_

INSURANCE INFORMATION:

In order to avoid error or delay in the processing of any insurance claims, it is essential that this section be COMPLETELY FILLED OUT.

Do you have health insurance? YES NO (Circle One)

PRIMARY INSURANCE SECONDARY INSURANCE

Insurance Company \_\_\_\_\_ Insurance Company \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ Ins. Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder \_\_\_\_\_

Social Security No. \_\_\_\_\_ Social Security No. \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Group No. \_\_\_\_\_ ID No. \_\_\_\_\_ Group No. \_\_\_\_\_ ID No. \_\_\_\_\_

Due to the large number of insurance policies that come across our desk every day, we cannot possibly keep up with the specifics of each one. Therefore, we rely on you to know your insurance benefits. When you come in, we will take a copy of your insurance card to assure proper billing, but you should know when you need a referral and whether or not you have a co-pay.

Claim #

DATE OF INJURY \_\_\_\_\_ *Auto or Workers Comp (disclose)*

NAME OF CARRIER \_\_\_\_\_

ADDRESS OF CARRIER \_\_\_\_\_  
STREET

CITY STATE ZIP

PLEASE SIGN BY BOTH X'S!

I authorize payment of medical benefits to undersigned physician or supplier for these services and all future claims.

X \_\_\_\_\_  
Signed (Insured or Authorized Person)

I authorize the release of any medical information necessary to process this claim and all future claims.

X \_\_\_\_\_  
Signed (Insured or Authorized Person)