Doctor: ____________________

PATIENT INFORMATION

Name: ____________________
Address: ____________________
____
City,State, Zip: ____________________
Primary Phone: (   ) ____________________
Alt Phone: ____________________
Mobile/Pager Phone: ____________________

Patient ID #: ____________________ Sex: [ ]M [ ]F
Date of Birth: ____________________ Age: ____________________
Driver's License #: ____________________
Social Security #: ____________________
Marital Status: [ ]Married [ ]Single [ ]Divorced
Referring Physician: ____________________
Primary Physician: ____________________

PATIENT EMPLOYMENT INFORMATION

[ ]Employed [ ]Retired [ ]Unemployed [X]Other
Employer's Name: ____________________
Employer's Phone: ____________________
Occupation: ____________________

EMERGENCY CONTACTS

Name	Relationship	Phone

RESPONSIBLE PARTY *(If patient is under 18 years of age)*

Name: ____________________
Address: ____________________
____
City,State, Zip: ____________________

Employer: ____________________
Home Phone: ____________________
Work Phone: ____________________
SSN: ____________________
Date of Birth: ____________________

PRIMARY INSURANCE

Insurance Company Name: ____________________
ID #: ____________________
Group/Policy #: ____________________
Subscriber's Name: ____________________
Subscriber's Phone #: ____________________
Relationship to Patient: ____________________
Subscriber's Employer: ____________________
Subscriber's SS #: ____________________
Subscriber's Date of Birth: ____________________

SECONDARY INSURANCE

Insurance Company Name: ____________________
ID #: ____________________
Group/Policy #: ____________________
Subscriber's Name: ____________________
Subscriber's Phone #: ____________________
Relationship to Patient: ____________________
Subscriber's Employer: ____________________
Subscriber's SS #: ____________________
Subscriber's Date of Birth: ____________________

WORK RELATED INJURY

Only applicable if injury is related to work or auto accident

Insurance Carrier Name: ____________________ Address: ____________________
City, State, & Zip: ____________________ Phone: ____________________
Claim Number: ____________________ Date of Injury: ____________________ Employer @ time of Injury: ____________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

____________________ PATIENT/GUARDIAN SIGNATURE

____________________ DATE

03/04/2009