Doctor: ______________________

PATIENT INFORMATION

Name: ______________________
Address: ______________________
____
City,State, Zip: ______________________
Home Phone: ______________________
Work Phone: ______________________
Mobile/Pager Phone: ______________________

Race: ______________ Sex: [ ]M [ ]F
Date of Birth: ______________ Age: __________
Email Address: ______________________
Social Security #: ______________________
Marital Status: [ ]Married [ ]Single [ ]Divorced
Referring Physican: ______________________
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