PATIENT INFORMATION

Patient (Legal) Name: ______________________________

(Preferred Name): ______________ Previous/Maiden Name(s): ______________

Social Security #: ______________ Birth Date: ______________

Male: ☐ Female: ☐ EMAIL ADDRESS: ______________

Physical Address: ______________________________

Mailing Address: ______________________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Patient's Employer: ______________ Work Phone: ______________

Spouse Name: ______________ Phone: ______________ Spouse Soc. Sec. #: ______________

Spouse Birth Date: ______________ Spouse Employer: ______________ Spouse Work phone #: ______________

COMPLETE THIS SECTION IF PATIENT IS UNDER THE AGE OF 18 OR A STUDENT

Mother's Name: ______________ Father's Name: ______________

Mother's Social Security #: ______________ Father's Social Security #: ______________

Address: ______________________________

Mother's DOB: ______________ Employer: ______________ Work Phone #: ______________

Father's DOB: ______________ Employer: ______________ Work Phone #: ______________

NEAREST RELATIVE/FRIEND NOT LIVING WITH PATIENT

Name: ______________ Relationship: ______________

Address: ______________ Phone #: ______________

WHO CAN WE THANK FOR REFERRING YOU TO US?

☐ Doctor ☐ Family/Friend ☐ All other: ______________

IMPORTANT INFORMATION (PLEASE READ)

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.

I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered an agree that all proceeds of insurance are assigned to this office where applicable.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account.

PATIENT OR GUARDIAN SIGNATURE: ______________ DATE: ______________

PATIENT OR GUARDIAN SIGNATURE: ______________ DATE: ______________

PATIENT INFORMATION

(CONTINUED – TO BE FILLED OUT IF TREATMENT IS ACCIDENT RELATED)

Name: ______________________________ **Date:** ______________________

WORKER'S COMPENSATION

This information must be completed in order for us to bill for services. If it is not complete, the patient will be responsible for full payment at the time they are treated.

EMPLOYER AT TIME OF INJURY: ______________________ **Phone #:** ______________

ADDRESS: ____
STREET ADDRESS *CITY* *STATE* *ZIP*

SUPERVISOR: ______________________ **PART OF BODY INJURED:** ______________ **L** ☐ **R** ☐

In detail, explain how accident/injury occurred?

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DATE OF INJURY: ______________________ **LAST WORKED DATE:** ______________________

WORK COMP INSURANCE CARRIER: ______________________________

WORK COMP CARRIER ADDRESS: ______________________________
STREET ADDRESS *CITY* *STATE* *ZIP*

Does your work comp carrier require you to make co-payments to the Doctor? ☐ *yes* ☐ *No*

CLAIMS EXAMINER: ______________________ **PHONE #:** ______________

CLAIM #: ______________________________

AUTO ACCIDENT

POLICY HOLDER: ______________________________

CLAIM #: ______________________ **ACCIDENT DATE** ______________________

INSURANCE AGENCY: ______________________________

ADDRESS: ______________________________
STREET ADDRESS *CITY* *STATE* *ZIP*

AGENT: ______________________ **PHONE #** ______________________

OTHER INJURY

PLEASE EXPLAIN:

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