

Confidential Patient Information

(Please Print)

PATIENT INFORMATION

NAME: _____
Last First Middle Initial Driver License # - State

ADDRESS: _____
Street Apt # City State Zip Code

AGE: _____ DATE OF BIRTH: ____/____/____ HOME PHONE: _____ CELL NUMBER: _____
Month Day Year

EMPLOYER: _____ WORK PHONE NUMBER: _____

SS #: _____ OCCUPATION: _____

REFERRING DOCTOR: _____ PRIMARY CARE PHYSICIAN: _____

PHONE #: _____ PHONE #: _____

Spouse (or parent if patient is a minor).

NAME: _____
Last First Middle Initial Relationship

ADDRESS: _____
Street Apt # City State Zip Code

DATE OF BIRTH: _____ SS#: _____

EMPLOYER: _____ WORK PHONE NUMBER: _____

EMERGENCY INFORMATION

Emergency Contact (person not living with you).

NAME: _____ HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____ RELATIONSHIP: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION

Please present your insurance card to the front desk so a copy can be made.

PRIMARY INS. NAME: _____ SECONDARY INS. NAME: _____

INSUREDS NAME: _____ INSUREDS NAME: _____

SUBSCRIBER NO.: _____ SUBSCRIBER NO.: _____

GROUP NO: _____ GROUP NO: _____

INS. PHONE NUMBER: _____ INS. PHONE NUMBER: _____

COMPLETE ONLY FOR WORK/AUTO/OTHER INJURIES

Date of Injury _____ Name of person to contact for worker's comp. _____

Has an accident report been filed with your employer?
 Yes No Insurance Information _____

Claim # _____ Supervisor's Name _____

INS. Phone # _____ Phone Number _____

I authorize payment of medical benefits to undersigned physician or supplier for these services and all future claims. I authorize the release of any medical information necessary to process this claim and all future claims. I am responsible for the total amount of charges regardless of any insurance coverage.

Date _____

X _____
Signed

Date _____

Interpreter Signature (if necessary) _____