PATIENT INFORMATION

Date _____ Referred By _____

Primary Care Physician _____ City _____ State _____

Name _____ Birthdate _____
(Patient LAST name) (First) (MI)

Address _____
Street City State Zip

Mailing Address (if different from above) _____

Telephone Number (Home) _____ (Cell) _____ (Work) _____

Marital Status _____ Social Security Number _____ Age _____

Employer's Name _____ Occupation _____

Employers Address _____ Phone _____

Parent/Guardian Name:_____ Birthdate _____Soc. Security #_____
(LAST name) (First) (MI)

Parent/Guardian Address: _____
Street City State Zip

Parent/Guardian Employer _____ Employer Phone _____

Spouse Name _____ Employer _____

Spouse Employer Address _____ Phone _____

Additional Contact Information

Name of friend/relative (not living with you) _____

Relationship _____ Phone _____

Accident/Injury Information

Was this an accident? ❑ No ❑ Yes: ❑ Auto ❑ Work ❑ Other _____

Are you represented by an attorney? ❑ No ❑ Yes **Date of injury** _____

WHO WILL WE BE BILLING _____

Insurance Company _____ Phone _____

ID# _____ Group # _____

Subscriber _____ Birthdate _____ Sex _____ Relationship _____

Insurance Company _____ Phone _____

ID# _____ Group # _____

Subscriber _____Birthdate _____Sex _____Relationship_____

I hereby authorize the release of all medical information necessary to process claims and authorize my insurance company to make payments directly to the Doctor. I understand and agree that I am personally responsible for any balance on my account regardless of insurance coverage and/or litigation that may be pending. I understand and agree that I will be charged an annual finance charge of 18% for any unpaid balances greater than 60 days. I also authorize the release of medical information to my primary care physician for updating purposes. **IF I DO NOT SIGN THIS AGREEMENT, I UNDERSTAND THAT PAYMENT WILL BE EXPECTED AT THE TIME OF SERVICE.**

Signature _____ Date _____