



PATIENT INFORMATION

PATIENT NAME: _____

LAST FIRST MIDDLE

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE #: _____ WORK PHONE #: _____

OTHER PHONE #: _____ Email: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: (circle one) SINGLE MARRIED SEPERATED DIVORCED WIDOWED

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one)

SELF SPOUSE CHILD OTHER: _____

SEX: (circle one) FEMALE MALE

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

Employed (please circle): Full time Part time Unemployed Student

PATIENT'S EMPLOYER INFORMATION:

COMPANY: _____ CITY: _____

PHONE #: _____

ACCIDENT INFORMATION:

DATE OF ACCIDENT: _____

TYPE OF ACCIDENT: (CIRLCLE ONE) WORK RELATED AUTO OTHER: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

CHECK BOX IF INFORMATION IS SAME AS ABOVE

RESP. PARTY NAME: _____

LAST FIRST MIDDLE

ADDRESS: _____

APT#: _____ CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SEX: (circle one) FEMALE MALE

HOME PHONE #: _____ WORK PHONE #: _____

SOCIAL SECURITY NUMBER: _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION:

Employed (please circle): Full time Part time Unemployed Student

COMPANY: _____ CITY: _____

PHONE #: _____



INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

SUBSCRIBERS (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: \$ _____ SUBSCRIBER'S DATE OF BIRTH: _____

SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER'S (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: \$ _____ SUBSCRIBER'S DATE OF BIRTH: _____

EMERGENCY CONTACT:

NAME: _____ **PHONE #:** _____

NAME: _____ **PHONE #:** _____

I have read and understand the medical treatment and financial agreement and agree to follow the terms as provided within. I am the patient, the parent of a minor child, or the legally authorized representative of the patient and am duly authorized to act on behalf of the patient and to sign this agreement. **(See Medical Treatment and Financial Agreement Attached to clipboard)**

Patient/Guardian Signature: _____

Relationship to Patient (please circle one): Self Mother Father Legal Guardian

Other: _____