

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: M  F   
(First - Middle Initial - Last)

Nickname: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ SS#: \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Marital Status: Married  Single  Divorced  Widowed

Phone: Home \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Phone: Work \_\_\_\_\_

Phone: Cell \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**EMPLOYMENT INFORMATION:**

**EMERGENCY CONTACTS:**

Employer: \_\_\_\_\_

Name: Relationship: Phone #: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Retired  Unemployed  Other

**INSURANCE INFORMATION:**

Primary Insurance Co: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_

ID#: \_\_\_\_\_

ID#: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_

Subscriber:  
Name: \_\_\_\_\_

Subscriber:  
Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

**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 to furnish information regarding my illness/injury to my insurance carrier. I understand that I am responsible for any amount not paid for by my insurance.**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**MVA or WORK RELATED INJURIES ONLY**

Insurance carrier name: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Claim #: \_\_\_\_\_ Date of injury: \_\_\_\_\_ Employer @ time of injury \_\_\_\_\_