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REFERRED BY / PRIMARY CARE PROVIDER:_____
FIRST NAME: _____ LAST NAME: _____
ADDRESS: _____ APT#_____
CITY/STATE:_____ ZIP CODE_____
DATE OF BIRTH:_____/_____/_____SSN:_____-_____-_____SEX:_____
MARITAL STATUS:_____
HOME PHONE NUMBER:_____
CELL PHONE NUMBER:_____
PREFERRED CONTACT NUMBER:_____

EMERGENCY CONTACT: _____ RELATIONSHIP:_____
HOME PHONE NUMBER:_____
CELL PHONE NUMBER:_____

PRIMARY INSURANCE COMPANY:_____
GROUP POLICY NUMBER:_____GROUP NAME:_____
INSURED:_____INSURED SSN:_____-_____-_____INSURED DOB:_____

SECONDARY INSURANCE COMPANY:_____
GROUP POLICY NUMBER:_____GROUP NAME:_____
INSURED:_____INSURED SSN:_____-_____-_____INSURED DOB:_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OR ALL CHARGES INCURRED ON BEHALF OF MYSELF AND MY FAMILY REGARDLESS OF INSURANCE BENEFITS.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIMS ON MY BEHALF AND REQUEST PAYMENT OF INSURANCE PROCEEDS INCLUDING ANY MAJOR MEDICAL BENEFITS TO THE ABOVE PHYSICIAN OR CLINIC. THIS WILL ALSO SERVE AS AUTHORIZATION FOR THIS OFFICE TO OBTAIN INSURANCE INFORMATION FROM MEDICARE REGARDING ANY CLAIMS THIS OFFICE SUBMITTED ON MY BEHALF.
A COPY OF THESE SIGNATURES ARE AS VALID AS THE ORIGINAL.

WE DO NOT FILE WORKERS' COMPENSATION. IT IS YOUR RESPONSIBILITY TO INFORM US OF A WORK RELATED INJURY.

PATIENT NAME
(PRINT)_____

SIGNATURE:_____DATE:_____