Please Complete All Questions

PATIENT'S LEGAL NAME_______________________________________ **Sex- M F** Birth Date________________

Address___________________________________City/State______________________ZipCode______________

Home Phone (____) ________-___________ Social Security#____________________

Cell Phone (____) ________-______________ Cell Carrier_______________________

Employer________________________________ Work Phone (____) _____-__________

Spouse's Name__________________________ Marital Status S__M__W__D__Sep.__

Physician Referral Name____________________ Family Doctor_____________________

Why are you here to see the doctor?

Reason___________________________________ **How did it happen?**______________________

Date this began__________________________ **Worker's Comp.?**_________________________

If patient is a minor, please complete:

Mother____________________________________ Social Security#____________________

Employer_________________________________ Work Phone (___) _____-___________

Father_____________________________________ Social Security#____________________

Employer_________________________________ Work Phone (___) _____-___________

Emergency Contact Information

(If you are not home, who may leave a message with)

Name_______________________________Relationship______________________ Phone (____) ____-___________

Patient Portal – Would you like to access your health information online?

Yes____ No____ Do you want to receive text messages? Yes___ No_____

Email address__________________________

Insurance Information

Primary Insurance________________________ ID#_________________________ Group#_________________

Policyholder's Name______________________ SS#_______________________ Birth Date_______________

Secondary Insurance_______________________ID#________________________ Group#__________________

Policyholder's Name_______________________ SS#_______________________ Birth Date_______________

It is understood and agreed that all professional services must be paid for at the time the service is rendered unless prior arrangements are made with the office. Even though an insurance claim may be filed, you are responsible for the total amount of your account and will receive a statement if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim.

I authorize the release of any medical or other information necessary to process a claim and payment of medical benefits to the treating physician.

Patient, Parent or Guardian's Signature_________________________________ Date________________________