

# Patient Information

Please Print

Date: \_\_\_\_\_

<b>Name:</b>	<b>Male</b>	<b>Female</b>	<b>Birthday</b>			<b>Marital Status</b>	
						Single	Married
<b>Address:</b>	<b>SS#</b>						
<b>City:</b> <b>State:</b> <b>Zip:</b>	<b>Employer:</b>						
<b>Home Phone:</b> (        )	<b>Spouse:</b>			<b>Birthdate:</b>			
<b>Cell Phone:</b> (        )	<b>SS#</b>			<b>Employer:</b>			
<b>Work Phone:</b> (        )	<b>Email:</b>						
<b>Email:</b>	<b>In Case Of Emergency:</b>						

**Reason For Visit:** \_\_\_\_\_

**Previous Treatments for This Condition:** \_\_\_\_\_

**Other Doctors Seen For This Condition?** \_\_\_\_\_ **When Did Your Symptoms Begin?** \_\_\_\_\_

**Were You In An Accident? Yes / No**              **Date of the Accident:** \_\_\_\_/\_\_\_\_/\_\_\_\_              **Auto**    **Home**    **Work Related**    **Other**

**Please Describe:** \_\_\_\_\_

**Do You Have An Attorney? Yes / No**    **Name:** \_\_\_\_\_ **Address** \_\_\_\_\_

**Primary Carrier Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**Insured** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Name & ID# on card** \_\_\_\_\_

**Grp #** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

**Relationship to Patient:** Self    Spouse    Child    Other

**Secondary Carrier Name:** \_\_\_\_\_

**Insured ID #** \_\_\_\_\_ **Grp #** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

**Insurance:** If you have medical insurance, we will be glad to process your claims for you as a courtesy of this office.

**Pay Arrangements:** If you are not covered under insurance, arrangements can be made through the receptionist.

**Authorized Consent For Treatment of A Minor**

\_\_\_\_\_  
 Signed by              Mother    Father    Other

To submit a claim for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.**

I understand that I am financially responsible for any balance not covered by my insurance carrier.

I also direct this office to do all acts necessary to recover all or any part of these sums payable to me.

A copy of this signature is as valid as the original.

I attest that the above information is accurate to the best of my ability.              Signed \_\_\_\_\_