

WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____
Street Apt# City, State, Zip

Phone # (H) _____ (W) _____ (Cell) _____

What phone # is best for us to contact you? (H) (W) (C)

Date of Birth: _____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Race Caucasian African American Asian Native American Latin American Other _____

Ethnicity Hispanic Latino Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____

Phone #: (H) _____ (W) _____ (Cell) _____

Accident Information

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other _____

Has it been reported? Yes No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B.: _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.