DEMOGRAPHICS

Patient Name: _____ Sex: ☐ Male ☐ Female
Last First Middle

Race: (Please Circle One) Asian, African American, American Indian, Caucasian, Hispanic, Other, Patient Declined

Date of Birth: _____ Social Security #: _____

Home Phone #: _____ Cell Phone #: _____

Street Address: _____
Street or Route Apt # City State Zip

Marital Status: ☐ S ☐ M ☐ W ☐ D Spouse Name: _____ Cell Phone #: _____

Referred to: Dr. _____ By: _____

Who is your Primary Care Physician? _____ Office Phone # _____

Reason for Office Visit (Type of Injury/Problem/Illness): _____

Diagnostic Testing in past 1 Month: Yes / No Where were the tests done? _____

Is the Patient currently Employed? ☐ Yes ☐ No Financial Responsibility: ☐ Self ☐ Other

Patient's Employer: _____ Address: _____
Street City State Zip

Occupation: _____ Work Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ Insurance ID #: _____
Subscriber Name: _____ Subscriber DOB: _____
Subscriber S.S. #: _____ Relationship to Subscriber: _____

Secondary Insurance: _____ Insurance ID #: _____
Subscriber Name: _____ Subscriber DOB: _____
Subscriber S.S. #: _____ Relationship to Subscriber: _____

Is this a Work Comp Injury/Claim? ☐ Yes ☐ No Insurance Name: _____ Phone: _____

IN CASE OF EMERGENCY

Name of local relative or friend (not living at same address): Relationship: _____

NAME: _____ Phone: _____

Address: _____
Street City State Zip

Authorization for Treatment and Financial Agreement: I do hereby consent to medical care encompassing such diagnostic procedures and medical treatment performed on me or ordered by my physician, his assistants, as is necessary in the judgment of my physician. I hereby authorize direct payment to physician of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by Provider of services to the Patient. I understand that I am financially responsible for charges not covered by insurance benefit and guarantee payment for such charges. Release of Information: I hereby authorize the treating physician to release, to the extent permitted by law, any medical information acquired in the course of the Patient's examination and/or treatment to any insurance company assisting in payment of medical care provided. I also hereby authorize the release of any medical information to any licensed physician or facility to which Patient may be referred for further medical care.

Signature: _____ Please Check One: ☐ Patient
☐ Parent or Guardian of Minor
Date: _____ ☐ Authorized Representative

Above information verified each office visit:
Dates Verified: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____