CONFIDENTIAL PATIENT INFORMATION

DATE ___/___/___

PLEASE PRINT

PATIENT INFORMATION:

FULL NAME________________ DATE OF BIRTH ___/___/___ AGE ___ Male☐ Female☐

ADDRESS________________ APT#______ SSN _____-____-_____

CITY ____________ STATE _____ ZIP CODE __________ HOME PHONE (_____)__________

ALTERNATE PHONE (CELL): (_____)__________ EMAIL ADDRESS: __________

EMPLOYER'S NAME __________ OCCUPATION __________

WORK ADDRESS __________ CITY __________ STATE ____ ZIP __________

WORK PH. # (_____)__________ EXT.__________ DATE SYMPTOMS BEGAN: ___/___/___

MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? __________

EMERGENCY CONTACT __________ PHONE__________

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT ☐ A PERSONAL INJURY ☐ A WORK INJURY ☐ OTHER ☐

TYPE OF CLAIM: CASH ☐ GROUP HEALTH INS ☐ PERSONAL INJURY ☐ WORKER'S COMP ☐ MEDICARE ☐

I WILL BE PAYING TODAY BY CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER ☐ OTHER ☐

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF ☐ SPOUSE ☐ OTHER ☐ CHILD ☐ SPOUSE: __________

INSURED'S EMPLOYER SAME AS ABOVE ☐ __________

INSURED'S SSN SAME AS ABOVE ☐ SSN _____-____-_____ INSURED'S DOB SAME AS ABOVE ☐ ___/___/___

PRIMARY INSURANCE CO.__________ ADDRESS __________

CITY __________ STATE _____ ZIP CODE __________ PHONE#(_____)__________

POLICY NUMBER __________ GROUP NUMBER __________

....

SECONDARY INSURANCE CO.__________ ADDRESS __________

CITY __________ STATE _____ ZIP CODE __________ PHONE#(_____)__________

POLICY NUMBER __________ GROUP NUMBER __________

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: __________ Date: __________

Guardian Signature: __________ Date: __________