PATIENT INFORMATION

NAME: _____ SOCIAL SECURITY #: _____ GENDER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE #: _____ SECONDARY PHONE #: _____

MAY WE LEAVE A MESSAGE ON YOUR PRIMARY PHONE: Y / N SECONDARY PHONE: Y / N

DATE OF BIRTH: _____ AGE: _____ DRIVER LICENSE #: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

PHONE: _____ RELATIONSHIP: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

-FILL OUT IF INFORMATION WAS NOT ALREADY PROVIDED-

TYPE OF INSURANCE: Private _____ Worker's Comp _____ Medicare _____ Self-Pay _____

NAME OF INSURANCE COMPANY: _____

NAME OF POLICY HOLDER: _____

FOR WORKER'S COMP: Date of Injury: _____ Claim Number: _____

Adjuster Name: _____ Adjuster Phone #: _____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE:	REASON FOR SURGERY/HOSPITALIZATION:

I hereby give lifetime authorization for payment or insurance benefits to be made directly to this healthcare provider for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and attorney fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to this healthcare provider. I consent to have this healthcare provider provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked at any time in writing.

PATIENT SIGNATURE or PARENT / GUARDIAN SIGNATURE **DATE**