

**PATIENT INFORMATION**

SOCIAL SECURITY # \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_  
LAST NAME \_\_\_\_\_  
SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
MARITAL STATUS     MARRIED     SINGLE  
                           DIVORCED     WIDOWED  
 EMPLOYED  RETIRED  FULL TIME STUDENT  OTHER  
EMPLOYER \_\_\_\_\_  
HOW DID YOU HEAR OF US? \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
\_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
EMAIL \_\_\_\_\_  
HOME PHONE \_\_\_\_\_  
WORK PHONE \_\_\_\_\_  
REFERRING PHYSICIAN \_\_\_\_\_  
REF PHY ADDRESS \_\_\_\_\_  
REF PHY PHONE \_\_\_\_\_

**INSURANCE INFORMATION**

**PLEASE PROVIDE YOUR DRIVER'S LICENSE AND INSURANCE CARD TO THE RECEPTIONIST**

Commercial  Medicaid  Medicare  Worker's Compensation  Other \_\_\_\_\_  
INSURANCE COMPANY \_\_\_\_\_  
INSURED / CARD HOLDER'S NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
POLICY# \_\_\_\_\_ GROUP # \_\_\_\_\_ PHONE \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Commercial  Medicaid  Medicare  Worker's Compensation  Other \_\_\_\_\_  
INSURANCE COMPANY \_\_\_\_\_  
INSURED / CARD HOLDER'S NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
POLICY# \_\_\_\_\_ GROUP # \_\_\_\_\_ PHONE \_\_\_\_\_

**WORKER'S COMPENSATION INSURANCE**

COMPANY NAME \_\_\_\_\_ COMPANY PHONE \_\_\_\_\_  
SUPERVISOR'S NAME \_\_\_\_\_ SUPERVISOR'S PHONE \_\_\_\_\_

**EMERGENCY CONTACT**

SOCIAL SECURITY # \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
LAST NAME \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**SPOUSE / GUARANTOR / RESPONSIBLE PARTY**

SOCIAL SECURITY # \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
LAST NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits. If any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

\_\_\_\_\_  
SIGNATURE (Patient or Parent if Minor)

\_\_\_\_\_  
DATE