



Doctor you are seeing: _____ Today's Date: _____

Patient Name: _____ Home Phone: () _____

Home Address: _____ Work Phone: () _____

City/State: _____ Zip: _____ Date of Birth: _____

Marital Status: S M W D Sex: M F Social Security #: _____ - _____ - _____

Are you under 18 years of age? Y N

Spouse/Nearest Relative: _____

If YES, Name of responsible party/How Related: _____

Address: _____

Address: _____

City/State: _____

City/State/Zip: _____

Contact Phone: () _____

Contact Phone: () _____

How Related: _____

Is this person authorized to receive information regarding your health? Y N

Employer's Name: _____

Address: _____

Referring Doctor's Name: _____

City/State: _____

Address: _____

Employer's Phone: () _____

City/State/Zip: _____

Occupation: _____ Date last worked: _____

Phone: () _____

Primary Care MD's Name: _____

Pharmacy: _____ Phone: () _____

Address: _____

Address/City/State/Zip: _____

City/State/Zip: _____

Drug allergies or reactions: _____

Phone: () _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND DIRECT PAYMENT TO PHYSICIAN FOR TREATMENT RENDERED

This authorization or photo copy there of will authorize you to release or obtain all information regarding my condition to the specified physicians, hospitals, insurance companies and/or attorneys.

Patient Name (Please print)

Patient Signature
(If minor, parent or legal guardian must sign)

Date: _____

Please turn form over to complete insurance information →

Patient Name: _____ Date of Birth: _____

If your visit is related to a work injury, please fill out the WORKERS COMPENSATION INSURANCE INFORMATION in addition to your primary and secondary insurance.
If your visit is related to a motor vehicle accident please fill out the NO FAULT INSURANCE INFORMATION In addition to your primary and secondary insurance. Thank you.

PRIMARY INSURANCE



Insurance Name: _____

Address: _____

City/State/Zip: _____

Name of policy holder: (If other than patient)

Employer of policy holder: _____

Policy Number: _____

Group Number: _____

Effective date of policy: _____

Policy holder date of birth: _____

Policy holder SSN#: _____

SECONDARY INSURANCE

Insurance Name: _____

Address: _____

City/State/Zip: _____

Name of policy holder: (If other than patient)

Employer of policy holder: _____

Policy Number: _____

Group Number: _____

Effective date of policy: _____

Policy holder date of birth: _____

Policy holder SSN#: _____

WORKERS COMPENSATION INSURANCE

Insurance Name: _____

Address: _____

City/State/Zip: _____

Date of Injury: _____ WCB#: _____

Carrier Case Number: _____

Employer at time of accident : _____

Employer Address/City/State/Zip: _____

County where injured: _____

Name of case manager/adjustor: _____

Adjustor contact Phone: () _____

NO FAULT INSURANCE

Name of Policy Holder: _____

Insurance Name: _____

Address: _____

City/State/Zip: _____

Date of accident: _____ File No.: _____

Name of Attorney: _____

Address/City/State/Zip: _____

Phone: () _____

Please turn form over to complete patient information →