Welcome To Our Office

Patient's Name: _____ Date: _____
Last First Middle

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: (___)_____ Work: (___)_____ Ext_____ Cell(___)_____

Birthdate: _____Age: _____ SSN :_____ Sex: M F Single Married Widowed Separated Divorced

Insurance Information

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #:(_____)_____

Insured's Name: _____DOB:_____ SSN:_____

Group Number: _____ Policy ID Number: _____ Relationship to Patient: Self Child Spouse Other

[Secondary Insurance]
Name of Insurance Company: _____

Address: _____

City: _____State: _____ Zip: _____

Insured's Name: _____DOB:_____ SSN: _____

Group Number: _____Policy ID Number: _____ Relationship to Patient: Self Child Spouse Other
Relationship to Patient: Self Child Spouse Other

Referred by: Dr.:_____ Yellow Pages: Friend Insurance Newapaper Other _____

In case of emergency, contact: _____ Relationship: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

[Injuries and Accidents]
Were you injured at work? Yes No In an auto accident? Yes No

Date of Injury: _____ Is an attorney involved? Yes No

Name:_____

Address:_____ City:_____State:_____ Zip Code:_____

Telephone:_____ Did you report the accident to your employer? Yes No

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: (___) _____ Birthdate: _____ Age:_____

Occupation: _____ SSN::_____

Employer: _____ Years There: _____

Employer's Address: _____

City: _____State: _____ Zip: _____ Work Phone: (___) _____

Office visits co-pays or deductibles are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage. All HMO's, IPA's and EPO's require prior authorization for each office visit. This is your responsibility. If we do not receive the authorization, payment is due at the time of service.

Method of Payment: Cash Check Mastercard or Visa

Signature of Patient or Responsible Party:_____ Date: _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ Date: _____
Signature of Patient or Personal Representative

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority