Name _____ Social Security # _____
Last First Middle

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Declined

Race: ☐ African American ☐ American Indian, Alaska Native ☐ Asian ☐ Caucasian ☐ Native Hawaiian, Pacific Islander ☐ Other ☐ Declined

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed - *Interpreter Name* _____

Birthdate _____ Age _____ ☐ Male ☐ Female - *Interpreter Phone* _____

Home Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Email Address _____

PRIMARY CARE PHYSICIAN: _____ **REFERRED BY:** _____

EMPLOYMENT INFORMATION

Employer _____ Occupation _____

Employer Address _____ Work Phone _____

Spouse/Parent/Domestic Partner _____ D.O.B. _____

Spouse/Parent Employer _____ Work Phone _____

IN CASE OF EMERGENCY: relative to contact (not living with patient)

Name/Relationship _____ Phone _____

REASON FOR THIS VISIT: ☐ Illness ☐ Injury ☐ Job related injury ☐ Auto accident ☐ Other

Date of injury or onset of problem _____ Part of body injured _____ ☐ Right ☐ Left

How did this happen? _____

If you were hospitalized for this: Where _____ When _____

INSURANCE INFORMATION

Primary Insurance _____ ID # _____ Group # _____

Subscribers Name _____ Subscriber's D.O.B. _____ Relationship to subscriber ☐ self ☐ spouse ☐ child

Claims Billing Address _____ Phone _____

Secondary Insurance _____ ID # _____ Group # _____

Subscribers Name _____ Subscriber's D.O.B. _____ Relationship to subscriber ☐ self ☐ spouse ☐ child

Claims Billing Address _____ Phone _____

Worker's Comp / Auto Insurance Carrier _____ Group # _____

Address _____ Claim Mgr Name & Number _____ Date of Injury/Accident _____

If someone other than the PATIENT is responsible for payment, complete the following:

Name of the responsible party _____ Address _____

Relationship to patient Social Security # D.O.B.

I acknowledge that I am financially responsible for all charges. I hereby authorize my insurance benefits to be paid directly to my physician. I also authorize the doctor and/or insurance company to release any information required for this claim.

Note: If the patient is under 18 years of age, the accompanying parent is responsible for all bills.

Signature _____ **Date** _____

PLEASE FILL OUT, PRINT, AND BRING TO YOUR APPOINTMENT

Print Form

Last update: October 16, 2018