



(CLINIC USE ONLY)

PCP	ACCOUNT #
<input type="checkbox"/> NEW <input type="checkbox"/> UPDATE	
TODAY'S DATE	

PATIENT INFORMATION

PATIENT'S NAME		BIRTHDATE	SEX	HOME PHONE
LAST	FIRST	MIDDLE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
PATIENT'S ADDRESS				
CITY		STATE	ZIP	
PATIENT'S SOCIAL SECURITY NUMBER	HAVE YOU EVER BEEN HERE BEFORE?	IF SO, WHEN AND BY WHOM?		MARITAL STATUS
	<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> Other
PATIENT'S EMPLOYER		OCCUPATION		WORK PHONE
PATIENT'S WORK ADDRESS				EMPLOYED SINCE
CITY		STATE	ZIP	

SPOUSE/PARENT INFORMATION

<input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT IF PATIENT A MINOR		BIRTHDATE	SOCIAL SECURITY #
LAST	FIRST	MIDDLE	
EMPLOYER		OCCUPATION	PHONE AT WORK
<input type="checkbox"/> SECOND PARENT IF PATIENT A MINOR		BIRTHDATE	SOCIAL SECURITY #
LAST	FIRST	MIDDLE	
EMPLOYER		OCCUPATION	PHONE AT WORK

EMERGENCY CONTACT

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU	RELATION TO PATIENT	WORK PHONE
ADDRESS		HOME PHONE
CITY		STATE ZIP

INSURANCE INFORMATION

INSURANCE COMPANY #1	POLICY HOLDER	RELATION TO PATIENT	Policy Holder's Birthdate
LIST ALL NUMBERS (ALSO HAVE CARD AVAILABLE FOR THE RECEPTIONIST TO PHOTOCOPY)			\$CO-PAY\$
I.D. NUMBER	GROUP NUMBER		
INSURANCE COMPANY #2	POLICY HOLDER	RELATION TO PATIENT	Policy Holder's Birthdate
LIST ALL NUMBERS (ALSO HAVE CARD AVAILABLE FOR THE RECEPTIONIST TO PHOTOCOPY)			\$CO-PAY\$
I.D. NUMBER	GROUP NUMBER		

INJURY INFORMATION

PATIENTS INJURED IN A MOTOR VEHICLE OR OTHER NON-WORK INJURY PLEASE COMPLETE BELOW.

DATE OF INJURY	YOUR CHIEF COMPLAINT AS A RESULT OF INJURY	WHERE AND HOW DID ACCIDENT OCCUR
YOUR MOTOR VEHICLE INSURANCE	INSURANCE COMPANY'S ADDRESS	
ADJUSTER'S NAME IF KNOWN	ADJUSTER'S PHONE	CLAIM #

PATIENTS INJURED AT WORK MUST HAVE REPORTED INJURY TO EMPLOYER AND COMPLETE THE NEXT TWO LINES

WORKER'S COMP (INDUSTRIAL) INSURANCE CARRIER	DATE OF INJURY	EMPLOYER AT TIME OF INJURY
CARRIER'S ADDRESS	CLAIM #	
CITY	STATE	ZIP

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC.

PATIENT SIGNATURE _____
 (PARENT IF PATIENT IS A MINOR)

DATE _____