PATIENT INFORMATION

Name: _____
First Middle Initial Last

Address: _____
Street City State Zip

Age: _____ DOB: _____ Sex: ☐M ☐F SSN: _____

Daytime Phone: _____ Evening Phone: _____

Employer: _____ Occupation: _____

Marital Status: ☐S ☐M ☐S ☐D ☐W Spouse's Name: _____

Referring Physician: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Daytime Phone: _____ Evening Phone: _____

INSURANCE INFORMATION

Primary Insurance Co: _____ ID# _____ Group# _____

Subscriber Name: _____ Relationship to patient: _____

Medicare ID# _____ Medicaid ID# _____

Secondary Insurance Co: _____ ID# _____ Group# _____

Subscriber Name: _____ Relationship to patient: _____

ACCIDENT INFORMATION

Is this visit because of an accident? ☐ yes ☐ no, If yes, please give date of accident: _____
Accident was due to: ☐auto ☐work ☐other: _____
Insurance Co. name, address, claim#, adjuster, phone: _____
_____

RELEASE OF INFORMATION/PAYMENT AUTHORIZATION

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.

_____ _____
Signature Date

Form provided by Healthcommunities.com 1.888.950.0808