

# Patient Information

PATIENT'S NAME \_\_\_\_\_  
(Last) (First) (Middle Initial)

ADDRESS \_\_\_\_\_  
(Street, PO Box, RFD#)

\_\_\_\_\_  
(City) (State) (Zip Code)

PLEASE CHECK THE BOX NEXT TO THE NUMBER TO CALL TO CONFIRM APPOINTMENTS

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_  DAY/WORK PHONE (\_\_\_\_\_) \_\_\_\_\_  CELL (\_\_\_\_\_) \_\_\_\_\_

SOC. SEC. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX: M F

MARITAL STATUS: M S D W NAME OF PRIMARY CARE PHYSICIAN: \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ WOULD YOU LIKE TO RECEIVE OUR  
NEWSLETTERS VIA E-MAIL? Yes No (We will never share, rent or sell your information to a third party.)

NAME OF EMPLOYER \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

## GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PATIENT AND ACCOUNT)

NAME OF SPOUSE/PARTNER/PARENT \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_

PHONE (\_\_\_\_\_) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

## INSURANCE INFORMATION – WE WILL NEED A COPY OF YOUR CARD

INSURANCE NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(Street, PO Box) (City) (State) (Zip Code)

POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

NAME OF POLICY HOLDER \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

POLICY HOLDER EMPLOYER \_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(Street, PO Box) (City) (State) (Zip Code)

HMO PATIENTS: DO YOU HAVE A REFERRAL? \_\_\_\_\_

IS THIS COVERED BY WORKMAN'S COMPENSATION? \_\_\_\_\_ IS SO, FILE # \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(Street, PO Box) (City) (State) (Zip Code)

**A CHARGE WILL BE MADE FOR BROKEN APPOINTMENTS UNLESS 24 HOUR NOTICE IS GIVEN**