Please print and complete this form in its entirety

Doctor:

PATIENT INFORMATION (The person seeing the physician)

Patient Name-First, Middle, Last	Preferred Name	Date of Birth	Marital Status: single married other
Address (Street)	City	State	Zip Code

What is your preferred method of contact? Primary Phone Secondary Phone Email Text

Primary Phone Type	Secondary Phone Type	Email

Sex: M F	Social Security#	Referring Physician	Primary Care Physician

Government regulations require us to ask the following: I choose not to answer ○

Language	Race	Ethnicity

GUARANTOR INFORMATION (The responsible party)

Guarantor Name-First, Middle, Last	Address - Street, City, State, Zip		
Primary Phone	Secondary Phone	Email	
Social Security#	Date of Birth	Sex M F	Employer

ADDITIONAL INFORMATION

How did you learn about our office?

Are you employed? Yes No Employer:

Are you a student? Yes No School:

INSURANCE INFORMATION (Present card to receptionist)

Primary Carrier	Carrier Phone#	Type: PPO HMO Medicare HSA/HRA Other	Copay

Insured Self Guarantor Spouse Child Other	Insured ID	Policy#	Group Name
Other Insured Name (if applicable)	Address - Street, City, State, Zip		

Date of Birth	Phone	Social Security#	Sex M F	Employer

EMERGENCY CONTACT (If patient is a minor, please list divorced parent information)

Name	Relationship	Phone

PHARMACY

Name	Address	Phone

ACKNOWLEDGMENT OF RECEIPT OF 'NOTICE OF PRIVACY PRACTICE'

I, _____, have received a copy of this office's Notice of Privacy Practices.

I hereby authorize the following persons to receive medical information regarding my care.

AUTHORIZATION LIST	Name	Relationship

_____

Acknowledgment Signature / Legal Guardian Signature

PATIENT ASSIGNMENT OF INSURANCE PAYMENT TO PHYSICIAN
RELEASE OF MEDICAL RECORDS TO INSURANCE CARRIER FOR PAYMENT

I hereby assign all medical and/or surgical payment benefits to my physician for medical services delivered by him or one of his representatives to me. This assignment of benefits for medical payment will remain in effect until revoked by me in writing or until all medical charges are paid for the services/supplies provided. NOTE: *Representatives include: physician partner, physician assistant, physical or occupational therapist.*

I understand that I am financially responsible for all charges not paid by my insurance carrier. *Exception: required provider discount. Please note: your insurance provider will clearly mark the required physician discounts on your Explanation of Benefits*. Charges will be adjusted per our contract with your insurance provider.

Should my insurance company require medical records from my physician or his representative, I authorize the release of those records to my insurance provider.

Patient Name: _____ Physician Name:_____

Patient / Legal Guardian Signature: _____ Date:_____

Is the problem you are being seen for today related to a motor vehicle accident? YES NO
If yes, date of accident:_____ State where accident occurred:_____

Is the problem you are being seen for today due to a work related injury? YES NO
Have you notified your employer of the injury? YES NO
Do you know if your employer has filed it to their insurance carrier? YES NO
What is/was the name of your employer at the time of the accident:_____
What is the date of injury?_____
Briefly describe how this work related accident occurred:
_____
_____
_____

If this is a work related injury but **you prefer it not to be filed to your workers' compensation carrier,** please note: It is your choice to ask us to file under your private insurance; however, we will be unable to go back and file to your work insurance. If that is your choice, please sign the acknowledgement below.
I prefer that you file my private insurance and not my workers' compensation insurance.

_____**Signature**_____**Date**

IF THIS IS NEITHER A MOTOR VEHICLE ACCIDENT NOR WORK RELATED INJURY, ARE YOU EXPECTING SOMEONE OTHER THAN YOUR INSURANCE CARRIER (OR YOU IF NO INSURANCE) TO PAY THIS BILL? YES NO

Who?_____
Why?_____
_____