REQUIRED INFO | Please fill out all fields in this box

Reason for visit: ❐ Work Injury ❐ Motor Vehicle Accident ❐ Pre-op Physical
Been here before? ❐Yes ❐No
Sex: ❐ Male ❐ Female Date of Birth: _______/_______/_______ Age:______ Soc Sec #:________-_______-________

***First Name:*_______________________________ *Middle Int:*_____ *Last Name:*______________________________________**

Street Address:____ Apt/Lot/Unit #:_________________

City:_____________________________________ State:_________ Zip:_____________________

Cell # ______________________________________Home # _____________________ Work # _____________________________

Email: ____

Current symptoms:____

How long have symptoms been present?____

Primary Care Doctor:______________________ Pharmacy Name: ______________________ Location# _____________________

Marital Status: ❐ Single ❐ Married ❐ Divorced ❐ Separated ❐ Widowed ❐ Partnered
Race / Ethnicity: ❐Caucasian ❐American Indian ❐African American ❐Asian ❐Hispanic ❐Other _________________
Primary Language: ❐ English ❐ Spanish ❐ Other _______________________________

Employer_____________________________________ Occupation: ___________________________________

Emergency Contact: Name:_______________________________________ Phone Number:_______________________________
Relationship to patient: ❐ Spouse ❐ Parent ❐Guardian ❐Friend ❐ Neighbor ❐ Other ____________

Insurance Information

Primary Ins Company:____

ID Number: ____ Group Number: ____________________________________

Subscriber Name: ____ Relationship to Patient: ____________________

Date of Birth:______/______/______ Social Security#: _______-______-_________ Employer: __________________________

Address: ❐Same as patient if different-Street Address:____

City:____________________________ State:___________ Zip: _______________

Secondary Ins Company:____

ID Number: ____ Group Number: ____________________________________

Subscriber Info: Name: ____Relationship to Patient: ___________________

Date of Birth: ______/______/______ Social Security #: _______-______-________Employer: __________________________

Address: ❐Same as patient if different-Street Address:____

City:____________________________ State:___________ Zip: ________________

Disclaimer: I certify that the above information is correct. I authorize treatment of myself (or my child if the pt is a minor). I agree that as the parent/guardian who brings in a minor to be seen that I am responsible for all bills if the correct insurance information is not provided at the time of service or if the insurance company denies the claim. I agree to pay any co pays due and agree to pay in full for all services not covered by insurance. I acknowledge that if I do not pay, my account may be turned over to a collection agency. I understand I am responsible for all collection costs. I also authorize release of treatment information for billing/medical legal purposes in addition to normal billing of services rendered. I have reviewed a copy of my HIPAA rights while in the office and if I request a copy I will be provided with one.