



Patient Name: _____ **Please Circle One:** Male Female

Date of Birth: _____ **Social Security No.:** _____

Referring Doctor: _____

Address: _____ **Apartment:** _____

City, State, Zip: _____

Phone Number: _____

Alternate Phone Number: _____

Emergency Contact: _____

Phone: _____

Full-time student: Yes No **If yes, name of college:** _____

Phone: _____ **Dates of Attendance:** _____ **Credit Hours:** _____

Accident Information

Date of injury: _____ **Circle one:** Work Related Auto Other

How injury occurred:

Responsible Party Info/Insurance Subscriber Info

Name: _____ **Relationship to Patient:** _____

Employer: _____ **Work Number:** _____

Date of Birth: _____ **Social Security No.:** _____

Address: _____ **Phone Number:** _____

My signature below indicates that I understand any remaining balance after insurance processing is my responsibility and that I also authorize my insurance company to send payment directly to the provider.

Signature: _____ **Date:** _____

Insurance Information

Please list below all insurance covering the patient. Insurance cards and/or signed claim forms can be accepted in lieu of this information.

Medical Insurance

PRIMARY MEDICAL: _____

Customer/Member Services Number: _____

Billing Address: _____

ID Number: _____ **Group Number:** _____

SECONDARY MEDICAL: _____

Customer/Member Services Number: _____

Billing Address: _____

ID Number: _____ **Group Number:** _____

Dental Insurance

PRIMARY DENTAL: _____

Customer/Member Services Number: _____

Billing Address: _____

ID Number: _____ **Group Number:** _____

SECONDARY DENTAL: _____

Customer/Member Services Number: _____

Billing Address: _____

ID Number: _____ **Group Number:** _____

I, _____, authorize the release of any medical information necessary to process my insurance claim and authorize my insurance company to send payment directly to the provider.

Signature: _____ **Date:** _____