Patient Information

Patient Name: _____ Today Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Date of Birth: _____ SS#: _____ Sex: M / F

Employer's Name: _____ Job Title: _____

Employer's Address: _____ City: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Health Insurance Information

Name of Insurance Company: _____ Insured Name: _____

ID Number: _____ Group Number: _____ Effective Date: _____

Address: _____ Phone Number: _____

Automobile Insurance Information

Name of Insurance: _____ Date of Accident: _____

Claim Number: _____ Name of Adjuster: _____

Phone: _____ Policy Number: _____

If represented by an attorney, please complete the following:

Name of Law Officer: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Fax: _____ Contact Person: _____

Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office. It is essential that if your insurance carrier sends you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible.

Patient Signature: _____ Date: _____