

PATIENT INFORMATION

Name: _____ SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home: () _____ Work: () _____
Fax: () _____ E-Mail: _____
Date of Birth: _____ Sex: M F Marital Status: _____
Employer: _____
Referring Physician (If Applicable) _____
In Case of Emergency Notify: _____ Phone: () _____

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Workers Compensation? Yes / No Accident? Yes / No
Claim #: _____ Injury Date: _____

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PRIMARY INSURANCE / WORKERS COMP.

Insurance Co.: _____ Phone: () _____
Address: _____
Policy #: _____ Group #: _____
Policy Holders Name: _____
Relationship to Patient: Self Spouse Parent Other: _____

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SECONDARY / OTHER INSURANCE

Insurance Co.: _____ Phone: () _____
Address: _____
Policy #: _____ Group #: _____
Policy Holders Name: _____
Relationship to Patient: Self Spouse Parent Other: _____

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I authorize the release of any medical information needed by a physician's office, insurance company or hospital. I authorize payment of the medical benefits directly to the physician for services.
I understand that I am financially responsible for all charges, whether or not they are covered by my insurance policy.

SIGNATURE: _____ DATE: _____
(patient, policy holder or responsible party)