CONFIDENTIAL PATIENT INFORMATION

DATE OF VISIT:_____

NAME:_____ PHONE: HOME_____ WORK_____

STREET_____

CITY_____ STATE_____ ZIP_____

DATE OF BIRTH_____ /_____/_____ AGE_____ SEX_____ MARITAL S M D W

E-MAIL ADDRESS_____

CHILDREN_____ NEAREST RELATIVE & PHONE_____

NAME OF EMPLOYER_____

ACCIDENT/INJURY: WORK_____ AUTO_____ DATE_____ LOST TIME_____

OTHER PHYSICIAN SEEN FOR THIS CONDITION_____

X-RAYS TAKEN? YES NO WHERE?_____ DATE_____

NAME OF PERSON RESPONSIBLE FOR PAYMENT_____

INSURED NAME_____

DRIVERS LICENSE NUMBER_____

YOU SS#_____ INSURED SS#_____

PRIMARY INSURANCE _____ POLICY #_____

SECONDARY INSURANCE_____ POLICY #_____

ATTORNEY OR INS ADJUSTER_____

Office hours allow our patients convenience to schedule appointments before and after work as well as during lunch. We are available to immediately see new patients the same day or through our 24 hour, 7 day emergency service. As a courtesy for you, we will call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards, please let is know in writing for your file. Our staff will try and verify your insurance coverage & benefits for you and we will submit insurance forms and information to your insurance carrier. You are responsible for costs of any services rendered to you or your minor child. Please ask any questions you may have regarding your bill and/or our fees to our insurance and billing department.

SIGNATURE_____

(if minor, parent must sign)