Please tell us how you were referred to our office. THANK YOU!

Primary Care Doctor:________________________________ **Referred By:**____

PATIENT INFORMATION: I prefer to be called: _____________________

Name:(Last)__________________________________**(LEGAL First)**________________________________**(M.I.)**______

Home Phone #: (_______)_______________________________ **Cell Phone #:** (_______)__________________________

Email:____________________________ **SSN:**_________________________ **D.O.B:**_____/_____/______ **Sex:** ______

Race: ☐ White ☐ American Indian ☐ Asian ☐ Black/African American ☐ Other:_____________ ☐ Decline

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Decline **Preferred Language:**___________________

Mailing Address: ____ **City:**______________________________

State:________ **Zip:** _______________________ **Patient status:** ☐ Single ☐ Married ☐ Other____________

Emergency Contact: Name:________________________ **Phone**: _______________________ Relationship________________

GUARANTOR/ PARENT INFORMATION:
(person responsible for the bill, if different from above) ***AN ADULT MAY NOT NAME ANOTHER ADULT RESPONSIBLE IF THAT PERSON IS NOT PRESENT***

Name:(Last)_____________________________ (First)__________________ (M.I.)____ Relationship:______________

Phone#: (_______)____________________________ Email:____

Address:____________________________________ Zip:_________ City:____________________________ State:_____

SSN:_________________________________ D.O.B:_______/________/__________ Sex: _____________

EMPLOYMENT STATUS: ☐ Empl FT ☐ Empl PT ☐ Retired ☐ Not Empl ☐ Student FT ☐ Student PT
(person responsible for the bill)

Employer's Name:____ Occupation: ________________________

Employer's Address:__________________________________City:__________________State:________Zip:____________

Employer's Phone: (________)_______________________________ May we contact you at work? ____________________

WORKMAN'S COMP:

Insurance Carrier:____________________________ Injury Date: _____________CLAIM #: _________________________

Employer's Name: ____________________________ Supervisor's name:__________________ Phone:_______________

PRIMARY INSURANCE:

Insurance Carrier:____________________________ Policy Holder Name: ____________________________ Gender:______

Policy Holder DOB:_____/______/________ Policy Holder SSN: _____________________ Relation to Patient:______________

Policy / ID #:____ Group #: __________________________________

SECONDARY INSURANCE:

Insurance Carrier:____________________________ Policy Holder Name: ____________________________ Gender:______

Policy Holder DOB:_____/______/________ Policy Holder SSN: _____________________ Relation to Patient:______________

Policy / ID #:____ Group #: __________________________________

By signing below, I agree that all the information provided is true to the best of my knowledge. I also hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for the noncovered services. I also authorize the physician to release any information required to process this claim.

SIGNATURE:____**DATE:**____________________