PLEASE PRINT

TODAY'S DATE:_____

PATIENT NAME:_____RESPONSIBLE PARTY NAME:_____
(Example: Parent of minor, POA)

BILLING ADDRESS:_____CITY, STATE, ZIP:_____

SUMMER ADDRESS:_____CITY, STATE, ZIP:_____

HOME PHONE:_____WORK PHONE:_____CELL PHONE_____

EMAIL ADDRESS:_____ PREFERRED METHOD OF CONTACT_____

SEX: □ MALE □ FEMALE BIRTHDAY:_____AGE:_____SOCIAL SECURITY #_____

RELATIONSHIP TO PT.: □ SELF □ SPOUSE □ CHILD □ OTHER IS PATIENT: SINGLE □ MARRIED □ DIVORCED □ WIDOWED

PRIMARY LANGUAGE:_____ RACE/ETHNICITY_____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY?:_____PHONE:_____

WHOM MAY WE THANK FOR REFERRING YOU TO US?:_____

IS YOUR EMPLOYER COVERED UNDER A UNION POLICY? ____YES ____NO ____I AM UNEMPLOYED

IS YOUR SPOUSE/PARENT EMPLOYED? ____YES ____NO ARE YOU ON THEIR POLICY? ____YES ____NO

ARE YOUR INJURIES WORK RELATED OR ACCIDENT RELATED ____YES ____NO

HAVE YOU/SPOUSE/PARENT EVER SERVED IN THE MILITARY? ____NO _____ACTIVE DUTY _____RETIRED

ARE YOU COVERED UNDER ANY OTHER HEALTH PLAN? _____YES _____NO

HAVE YOU MADE ANY CHANGES TO YOUR CHOICE OF HEALTH CARE PLANS, INCLUDING MEDICARE SINCE THE LAST OPEN ENROLLMENT PERIOD? _____YES _____NO

WHOM OVER THE AGE OF 18 IS RESPONSIBLE FOR THIS BILL?_____PHONE_____

INSURANCE INFORMATION:

MUST FILL IN ALL INFORMATION	**MUST FILL IN ALL INFORMATION**
PRIMARY INSURANCE:	SECONDARY INSURANCE:
INSURANCE CO. NAME:_____	INSURANCE CO. NAME:_____
INS. CO. ADDRESS:_____	INS. CO. ADDRESS:_____
POLICY HOLDER NAME:_____	POLICY HOLDER NAME: _____
EMPLOYER:_____	EMPLOYER:_____
POLICY NO:_____GROUP/CLAIM NO:_____	POLICY NO:_____GROUP CLAIM NO:_____
EFFECTIVE DATE:_____	EFFECTIVE DATE:_____
POLICY HOLDER SEX: □F □ M BIRTHDATE:_____	POLICY HOLDER SEX □ F □ M BIRTHDATE:_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

SIGNED (Patient or Parent if minor): _____Date:_____