Welcome To Our Office!

Name: _____ Date: _____
First Middle Last

Home Address: _____ Apt._____
City: _____ State: _____ Zip: _____
Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____
SSN: _____ Birth Date: _____ Age:_____

Email Address: _____

Employer Information:
Occupation: _____
Employer: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

Complete this section only if someone other than the patient is financially responsible.
Responsible Party: _____
Relationship to Patient: _____
Home Address: _____ Apt._____
City: _____ State: _____ Zip: _____
Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____
SSN: _____ Birth Date: _____ Age: _____
Occupation: _____
Employer: _____ Phone: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____

In case of emergency, contact: _____
Relationship to Patient: _____
Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

May we contact your emergency contact for billing or insurance matters? ☐ Yes ☐ No

How did you learn about our practice? _____
If someone referred you, whom may we thank? _____

Insurance Information

Name: _____ Date: _____
First Middle Last

Privacy Options:

Do you wish phone calls to be confidential? ☐ Yes ☐ No

May we contact you at work? ☐ Yes ☐ No

Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

May we contact you via e-mail or text regarding your appointments? ☐ Yes ☐ No

[Primary Insurance] ✱ Please enter information for the Insured Party.

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's Date of Birth: _____

Patient Relationship to the Insured Party: _____ Gender: _____

Policy ID Number: _____ Group Number: _____

[Secondary Insurance] ✱ Please enter information for the Insured Party.

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's Date of Birth: _____

Patient Relationship to the Insured Party: _____ Gender: _____

Policy ID Number: _____ Group Number: _____

Please answer the questions below if you are seeking medical services for an injury:

Did your injury happen on the job? ☐ Yes ☐ No

If "Yes," on what date did the injury occur? _____

Did you report the accident to your employer? ☐ Yes ☐ No

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay and non-covered service amounts.

Signature: _____ **Date:** _____