



## Patient Information Form

Medical Record # \_\_\_\_\_

**PATIENT** \_\_\_\_\_

Last Name \_\_\_\_\_ Legal Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Nickname \_\_\_\_\_  
 Address \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Social Security # \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Marital Status M S D  
 Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Male / Female

**PATIENT'S EMPLOYER** \_\_\_\_\_ Employer Phone# ( ) \_\_\_\_\_

Employer Address \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**NAME OF PERSON RESPONSIBLE FOR PAYMENT OF CHARGES FOR THIS PATIENT:** ( ) Patient  
( ) Other-Please complete the following

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Address if different from patient \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Social Security # \_\_\_\_\_ DOB \_\_\_\_\_ Male / Female  
 Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

### MEDICAL INFORMATION

Referred By \_\_\_\_\_ Family Physician \_\_\_\_\_  
 Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone # \_\_\_\_\_  
 Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Reason for Visit Today \_\_\_\_\_ Date of Injury/Onset \_\_\_\_\_

### INSURANCE INFORMATION (PLEASE LIST ANY AND ALL INSURANCE)

**Primary Insurance Co.** \_\_\_\_\_ Telephone# ( ) \_\_\_\_\_  
 Claims Address \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ Patient's Relationship to subscriber \_\_\_\_\_  
 Subscriber's DOB \_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_

**Secondary Insurance Co.** \_\_\_\_\_ Telephone# ( ) \_\_\_\_\_  
 Claims Address \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ Patient's Relationship to Subscriber \_\_\_\_\_  
 Subscriber's DOB \_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_

### Emergency Contact Information

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone# ( ) \_\_\_\_\_

I certify that the above information is accurate and truthful. I understand that I am financially responsible for all charges for services to myself, including the balance remaining after payment of possible insurance benefits. I authorize payment of medical expenses to the provider of professional services rendered. I authorize the release of any medical information necessary to process this claim.

 \_\_\_\_\_  
 Signature

 \_\_\_\_\_  
 Date