

PATIENT INFORMATION SHEET

Patient's Name (Last, First, MI)				Address (Street No.)			
City				State	Zip	Phone	
Patient's Employer				Occupation			Work Phone
Sex M ___ F ___	Marital Status Sgl ___ Mar ___ Oth ___		Patient's Birthdate MM ___ DD ___ YYYY ___		Age	Employment Status Empl ___ Ret ___ Stud ___ NA ___	
Disabled Y ___ N ___	Patient's SSN	Spouse's Name & Employer				Spouse's SSN	
Who Referred You to Us?				Who is your Primary Care Doctor?			
Person (not living with you) to notify in Emergency			Relationship	Address			Phone #
Primary Policyholder's Name			DOB	Sex M ___ F ___	Employer	Phone #	
Insurance Company		Policy #	Group #		Patient's Relationship to Policyholder Self ___ Spouse ___ Child ___		
Secondary Policyholder's Name			DOB	Sex M ___ F ___	Employer	Phone #	
Insurance Company		Policy #	Group #		Patient's Relationship to Policyholder Self ___ Spouse ___ Child ___		
Tertiary Policyholder's Name			DOB	Sex M ___ F ___	Employer	Phone #	
Insurance Company		Policy #	Group #		Patient's Relationship to Policyholder Self ___ Spouse ___ Child ___		
DATE OF INJURY / ONSET				Pharmacy Name			

MEDICARE INFORMATION

Statement to permit Medicare Payment to Provider

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Date: _____ Signature: _____

**SELF PAY PATIENTS

Self Pay Patients are required to pay a deposit of \$133.00 prior to being seen

Date: _____ Signature: _____

WORKER'S COMPENSATION PATIENTS

Date of Injury: _____ Has a claim been filed? Y ___ N ___

Employer's Name & Address _____

Compensation Carrier Name & Address _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize payment of the Surgical and/or Medical Benefits, if any, otherwise payable to me, directly to the Physician for his services as described. I realize that I am responsible for payment for non-covered services. I also authorize the Physician to release any information acquired in the course of my treatment that is necessary to process insurance claims.

Date: _____ Signature: _____