

PATIENT INFORMATION SHEET

Patient's Name (Last, First, MI)		Address (Street No.)		
City		State	Zip	Home/Cell Phone /
Patient's Employer		Occupation		Work Phone
Sex M ___ F ___	Marital Status Sgl ___ Mar ___ Div ___ Wid ___ Oth ___		Patient's Birthdate MM ___ DD ___ YYYY ___	Age
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 ___
ETHNICITY & RACE (CIRCLE ONE)				
HISPANIC / LATINO		AMERICAN INDIAN		ALASKA NATIVE
AFRICAN AMERICAN / BLACK		NATIVE HAWAIIAN		CAUCASIAN / WHITE
				ASIAN
				OTHER _____
DATE OF INJURY / ONSET			PHARMACY NAME	
BRANCH OF MILITARY SERVICE		UNIT NUMBER	UNIT PHONE NUMBER	EMAIL ADDRESS

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 \$176.00 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: _____