

PATIENT INFORMATION

Name \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status S M W D

Emergency Contact Person \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Employer Name \_\_\_\_\_

Phone \_\_\_\_\_ Your Occupation \_\_\_\_\_

INSURANCE INFORMATION

Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_

---

2<sup>nd</sup> Insurance \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_

---

Condition Related to Work? Y or N      Condition related to Auto accident? Y or N

Date of First Symptom \_\_\_\_\_ Condition Reported on \_\_\_\_\_

**CIRCLE** Total / Partial Disability

I hereby authorize the above stated clinic to release any information acquired in the course of my examination, which said insurance company may request.

I also assign and request payment of medical benefits to the above stated clinic for medical services. I also understand that I am financially responsible for any charges not covered.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Signature