

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, copay, and non-covered service amounts. See our complete financial policy for details.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
First Middle Last

Home Address: \_\_\_\_\_

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

Telephone (incl. area code): ( ) \_\_\_\_\_ Birth date: \_\_\_\_\_

Sex (circle one) M F Referring Doctor: \_\_\_\_\_

Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Employer's Address: \_\_\_\_\_

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

**Insurance Information**

**Please give a copy of your insurance cards to the receptionist**

**Primary Insurance**

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

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

Insured's Name: \_\_\_\_\_ Insured's Birth Date: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_

Insured's relationship to patient: \_\_\_\_\_ Insured's Sex (circle one) M F

**Secondary Insurance**

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

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

Insured's Name: \_\_\_\_\_ Insured's Birth Date: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_

Insured's relationship to patient: \_\_\_\_\_ Insured's Sex (circle one) M F

- \*Did your injury happen as a result of a motor vehicle accident? Yes No
- \*Has your injury prompted filing a personal injury claim? Yes No
- \*Did your injury happen on the job? Yes No
- \*Did you report the accident to your employer? Yes No
- \*Should we file your claims to Workman's Comp? Yes No

**\* If you answered yes, please ask receptionist for separate Accident Status forms.**

**Complete this section only if someone other than the patient is financially responsible.**

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Address: \_\_\_\_\_

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

Telephone: ( ) \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Years There: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

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

Work Phone: ( ) \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Years There: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

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

Employer's Telephone: ( ) \_\_\_\_\_

Emergency contact not living with you: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Do you wish correspondence and phone calls to be confidential? \_\_\_ Yes \_\_\_ No

If yes, whom do you authorize us to contact/talk to in case you are unavailable

May we contact you at work? \_\_\_ Yes \_\_\_ No

May we leave messages on the answering machine? \_\_\_ Yes \_\_\_ No

Do you have a living will? \_\_\_ Yes \_\_\_ No

\*If yes, please provide a copy for the receptionist.

Do you have a power of attorney? \_\_\_ Yes \_\_\_ No

\*If yes, please provide a copy for the receptionist.

Would you like information on power of attorney or living will? \_\_\_ Yes \_\_\_ No

**Signature of Patient or Responsible Party:** \_\_\_\_\_

**Date:** \_\_\_\_\_