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(please print)

Date ______________________________

Patient Name____Birthdate_______/_______/__________Age________
FIRST MIDDLE LAST

Mailing Address____City____________________State________Zip_____________

Home Phone____________________ Cell Phone________________________ Social Security # ____________________________

Occupation____ EMAIL ____

Sex: M / F Marital Status: S / M / W / D Referred By____

Emergency Contact (not living with patient)_______________________________________Phone_____________________________________

Relation to patient____

Insurance Company____ Policy # ____________________________________

Address ____ City ____________________________ State ________ Zip ____________

Phone ________________________________ Policy Holder's Relation to Patient (if not self) _____________________

Policy Holder Name_____________________________ Policy Holder's Date of Birth _____________________

Date of injury_______/________/__________ Place of Accident____

Briefly Describe Accident____ Job Related YES NO (please circle one)

I verify that all of the above information is true and correct. (If patient is a minor, parent/guardian please sign)

I authorize the release of medical information necessary to process my claim. As a courtesy to our patients we will file the claim with your insurance carrier with the understanding that the patient/guarantor, not your insurance company, is responsible for payment of this account. I accept responsibility for any charges from the physician, therapist or facility remaining after payment of insurance benefits. I authorize direct payment to the service provider.

Signed____Date____

Office use:
Copied insurance card Primary: **O** Secondary: **O**