

DATE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

METHOD OF PAYMENT:

       CHECK        CASH

       CREDIT CARD

       OTHER

**I. PATIENT INFORMATION**

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone # \_\_\_\_\_

Work Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_ Smoker: \_\_\_\_\_ Driver's License # \_\_\_\_\_

**II. NEXT OF KIN:**

Name: \_\_\_\_\_ Address & Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Work Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**III. INSURANCE INFORMATION:**

Medicare # \_\_\_\_\_

Medicaid # \_\_\_\_\_

Other:        GROUP        PPO        HMO        GROUP        PPO        HMO

(Primary)

(Secondary)

Name of Insurance Co.: \_\_\_\_\_ Name of Insurance Co.: \_\_\_\_\_

Address and Phone #: \_\_\_\_\_ Address and Phone #: \_\_\_\_\_

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

Insured's Social Security #: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_

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

Employer (if group policy): \_\_\_\_\_ Employer (if group policy): \_\_\_\_\_

**PAYMENT OF BENEFITS**

I direct payment to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described but not to exceed the reasonable and customary charge for those services.

\_\_\_\_\_  
Signed (Insured Person)

\_\_\_\_\_  
Date

**RELEASE OF INFORMATION**

I hereby authorize Physician to release any information acquired in the course of my examination or treatment.

\_\_\_\_\_  
Signed (Insured Person)

\_\_\_\_\_  
Date

A photostatic copy will be as valid as the original.

**IV. ACCIDENT INFORMATION:**

**PLEASE COMPLETE OTHER SIDE FOR JOB RELATED INJURY**

WORKER'S COMPENSATION:

DATE OF ACCIDENT: \_\_\_\_\_

NAME OF EMPLOYER: \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_

PHONE NUMBER OF INSURANCE COMPANY \_\_\_\_\_

ADDRESS OF INSURANCE COMPANY \_\_\_\_\_

ADJUSTOR'S NAME \_\_\_\_\_

CLAIM NUMBER \_\_\_\_\_