

Patient Information

Today's Date		Reason for Visit		Date of Injury / Illness	
Patient Number	Social Security No.	Last Name	First Name	MI	Birth Date
Address			City	State	Zip Code
Home Phone		Work Phone	Cell Phone		Gender
Appointment Reminder Contact Preference: <i>I authorize the following to be called for appointment reminders</i> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Do Not Contact <input type="checkbox"/>					
Employer Name		Employer Address, Phone		Patient Email Address: <i>I Authorize use for receipt of patient statements</i> <input type="checkbox"/>	
Marital Status (Circle One) Single / Married / Divorced Widowed / Separated		Employment Status (Circle One) Full Time / Part Time Not Employed / Self Employed Retired / Military Duty		Student Status (Circle One) Full Time / Part Time Not a Student	

GUARANTOR INFORMATION: COMPLETE ONLY IF DIFFERENT FROM PATIENT

Last Name		First Name		MI	Patient Relationship to Guarantor	
Address			City	State	Zip Code	
Home Phone		Work Phone		Cell Phone		
Gender	Birth Date	Social Security No.		Employer Name		
Employer Address		Employer Phone	Guarantor Email Address: <i>I Authorize use for receipt of patient statements</i> <input type="checkbox"/>			

EMERGENCY CONTACT

Emergency Contact	Home Phone	Work Phone	Emergency Contact Relationship to Patient
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PRIMARY INSURANCE

Fill in if no copy of card

SECONDARY INSURANCE

Insurance Name		Claims Address		Insurance Name		Claims Address	
City, State, Zip			Ins Ph. No.	City, State, Zip			Ins Ph. No.
Effective Date	Expiration Date	Subscriber Birth Date		Effective Date	Expiration Date	Subscriber Birth Date	
Subscriber Name			Policy No.	Subscriber Name			Policy No.
Subscriber SSN		Subscriber Employer		Subscriber SSN		Subscriber Employer	
Group Name			Group No.	Group Name			Group No.
Patient's Relation to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>							

GENERAL INFORMATION

Race (Circle One) American Indian/Alaska Native Asian Black / African American More than 1 race Native Hawaiian Other Pacific Islander White		Ethnicity (Circle One) Hispanic/Latino Non-hispanic/Non-Latino		Primary Language (Circle One) English Spanish Chinese Russian Other: _____	
		Do you need an interpreter? Yes / No			
How did you hear about us?					
Have you been seen here before? Yes / No			Primary Care Physician		
Is this visit due to a work-related illness/injury? Yes / No			If yes, please list the employer's name		
What is your pharmacy's name and location?					

Authorization To Pay Benefits To Provider: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my Provider when he/she accepts assignment.

Authorization To Release Medical Information: I hereby authorize my Provider to release any information necessary for my course of treatment.

Patient/Guarantor Signature

Date