PATIENT INFORMATION Date:_____

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City_____State:____Zip:_____

Phone: Home( )_____ Cell:( )_____

Email address: _____

Would you be interested in our monthly Newsletter ? Yes

How would you like to receive appointment reminders? Email ? Text? Phone? please circle one

Please make sure you have given us the email address or cell phone number you would like us to use above

Occupation:_____ Employer: _____

Emergency Contact:_____ **Phone**_____

Are you the subscriber of your health insurance policy? Yes

If No please tell us the name of the subscriber_____ Date of Birth_____

Responsible Party (if patient is under 18)_____Relationship to patient _____

Is this injury work related? Yes

Is this injury due to a car accident? Yes If yes: Do you currently have a lawyer involved with this case? Yes

Please tell us who kindly referred you to our clinic_____

BILLING INFORMATION

Have you provided us with a copy of your Insurance card/s? Yes If no please provide us with the following information:

Primary Insurance Co._____ Insurance Address_____

ID#_____Group #_____Policy #_____

Secondary Insurance Co._____ ID#_____ Group#_____

NOTE: Deductible, Copayments and Co-insurance Are due at the time of visit.

We accept VISA, MASTERCARD Credit Cards and HSA Accounts