

## PATIENT INFORMATION SHEET

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Parent/Spouse Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

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

Phone Number \_\_\_\_\_ SS# \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Referring Physician \_\_\_\_\_ Employer \_\_\_\_\_

Email Address \_\_\_\_\_  Check here to opt out of email marketing.

Auto Injury  Yes  No Work Comp  Yes  No Claim# \_\_\_\_\_ Date of Accident \_\_\_\_\_

## INSURANCE INFORMATION

Does Patient Have Insurance  Yes  No *If yes, complete the rest of form.*

*\*All of the questions below are regarding the policyholder NOT the Patient.*

**Primary Insurance** \_\_\_\_\_

Policyholder's name (If different from above) \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Policyholder's SS# \_\_\_\_\_ Employer \_\_\_\_\_

Policyholder's Marital Status \_\_\_\_\_ Patient's Relationship to Policyholder \_\_\_\_\_

**Secondary Insurance (If different from above)** \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Policyholder's SS# \_\_\_\_\_ Employer \_\_\_\_\_

Policyholder's Marital Status \_\_\_\_\_ Patient's Relationship to Policyholder \_\_\_\_\_

## EMERGENCY CONTACT

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

*\*I authorize the release of any information required to process claims, utilization review and quality assurances for services rendered and hereby assign my insurance benefits to be paid directly to my physician.\**

\_\_\_\_\_  
Signature of Patient or Guardian