

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 _____
Email Address _____ ☐ Check here to opt-out of email marketing.
Auto Injury ☐ Yes ☐ No Workers' 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 _____

Signature of Patient or Guardian

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.