PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, please answer all the questions below.

M / F / / S / M / W / D

Gender | Date of Birth (Month/Day/Year) | Age | Marital Status

Last Name | First Name | Middle Initial

Street Address

City | State | ZIP

Home Phone Number (include area code) | Cell Phone Number | e-mail address

Preferred Pharmacy Name & Location:_____

EMPLOYMENT INFORMATION

Patient's Employer (Parent's Name and Employer if Patient is a Minor) | Occupation | Work Phone #

Employer Street Address | City | State | Zip

IN CASE OF EMERGENCY

Who Should We Contact in Case of an Emergency (Name, Relation, and Phone #)

HIPAA PRIVACY POLICY

I have read & understand the HIPAA Privacy Policy Form:

_____ _____

Signature of Patient (or Parent/Guardian if patient is a Minor) | Print Name

RELEASE

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment directly to the doctor of any surgical and/or medical benefits, if any, otherwise payable to me for his services. I understand I am responsible for payment of all copays and deductibles as required by my insurance company.

_____ _____

Signature of Patient (or Parent/Guardian if patient is a Minor) | Date

WORKER'S COMPENSATION (if applicable)

Carrier | Address to Submit Claims | Claim Number Work / Auto

Adjuster's name | Adjuster's Phone Number | Date of Injury | Type of Injury