

WELCOME TO OUR OFFICE

Name _____ Date _____

Address _____ City _____ Zip _____ Phone _____

E-Mail Address _____ Cell Phone _____

Age _____ Birth Date _____ Patient Soc. Sec. No. _____

Type of Work _____ Student: Full Time Part Time

Employed By: _____ Business Phone _____

Address _____ Spouse Name _____

Spouse Employer _____ Business Phone _____

Insurance No. 1 _____ Insurance No. 2 _____

Address _____ Address _____

Group Name/No. _____ Group Name/No. _____

Policy Number _____ Policy Number _____

Name of Insured _____ Name of Insured _____

Insured Soc. Sec. No. _____ Insured Soc. Sec. No. _____

Other Insurance _____

Medical Doctor _____ Last Visit _____

IN CASE OF EMERGENCY, WHOM SHOULD BE NOTIFIED _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU. _____

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services.

I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

Signature _____ Date _____

I HAVE READ, AND AGREE TO THE ABOVE STATEMENTS.

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