



Name (last, first) _____, _____ **DOB** _____
Address _____ **City** _____ **State** _____ **Zip** _____
SS# _____ - _____ - _____ **Marital Status** _____ **Gender:** _____ Female _____ Male
Phone- Home: _____ **Work:** _____ **Cell:** _____
E-mail Address: _____ @ _____
Employer: _____ **Occupation:** _____ **Yrs. Employed:** _____

Referring Physician: _____ **Phone:** _____
Address _____
Primary Care Physician: _____ **Phone:** _____
Address _____
Therapist/Counselor: _____ **Phone:** _____
Address _____

EMERGENCY CONTACT

Name _____ **Relationship** _____
Home Phone: _____ **Work:** _____ **Cell:** _____

INSURANCE INFORMATION (all blanks must be filled in) Please provide insurance card(s) on day of visit.

SELF- PAY **WORKER'S COMP** **INSURANCE**

Primary INS Name: _____ **Policy Holder:** _____
ID: _____ **Group:** _____
SS# of policy holder _____ - _____ - _____ **DOB of Policy Holder:** _____
Employer of Policy Holder _____ **Relationship to Patient** _____
Secondary INS Name: _____ **Policy Holder** _____
ID: _____ **Group:** _____
SS# of policy holder _____ - _____ - _____ **DOB of Policy Holder:** _____
Employer of Policy Holder _____ **Relationship to Patient** _____

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, and authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services rendered.

Signature of Patient/Responsible Party: _____ **Date:** _____