

PLEASE COMPLETE THOROUGHLY

PATIENT NAME (Last) (First) (Middle Init.)

STREET OR BOX NO. CITY

STATE ZIP HOME PHONE WORK/CELL PHONE

Emergency Phone Emergency Name

SOC. SEC. # BIRTH DATE

CHECK ONE: Married Divorced Single Widowed SEX F M AGE

Patient Employer/School Occupation

Employer Address

SPOUSE OR PARENT INFORMATION (Circle One) If parent information, fill both name sections completely.

NAME ADDRESS CITY ST ZIP HM PH WK PH Soc. Sec. # Birth Date Employer Empl. Address

INSURANCE CARRIERS: (Please list ALL medical insurance coverage even if work related or auto accident.)

PRIMARY ID# GRP# Eff. Date

Subscriber name subscriber's DOB Patient's Relationship to subscriber

SECONDARY ID# GRP# Eff. Date

Subscriber name subscriber's DOB Patient's Relationship to subscriber

WHAT ARE WE SEEING YOU FOR TODAY?

WHEN DID INJURY/SYMPTOMS BEGIN? WHERE DID INJURY OCCUR?

JOB RELATED? YES NO AUTO ACCIDENT YES NO

Treatment in ER? Where? Date

PRIMARY CARE PHYSICIAN

REFERRING PHYSICIAN (who referred you to us?)

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize my signature on all insurance and Medicare claim forms at the office of Drs. Polio/Hulse for payment directly to him/her for service rendered to me/patient. I authorize this office to make and send copies of medical records that may be needed to file my insurance claims. I understand that I/patient am responsible for charges incurred regardless of whether my insurance pays or not. I/patient also understand that I am responsible for any attorney fees and court costs incurred in collecting any unpaid balances for services I/patient received. I agree that this statement applies to all current and future claims.

SIGNATURE DATE