



AUTO ACCIDENT ____ YES ____ NO
 WORK ____ YES ____ NO
 OTHER ____ YES ____ NO
 INJURY DATE: _____
 INJURY LOCATION: _____
 WHO REFERRED YOU _____

For Office Use Only
 New
 Change MRN: _____
 Copy of card attached

Patient Information

Name		Last		First		MI	
Other Name			Social Security #			Date of Birth	
Street Address			City			State	Zip
Home Phone #			Cell Phone #			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Primary Care Physician (PCP)			PCP Phone #			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	
Occupation		Employer			Employer Phone#		
Employer Address			City			State	Zip

Responsible Party Information Complete ONLY if not Patient

Name			Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent				
Street Address			City			State	Zip
Home Phone #			Employer Name				
Work Phone #			Employer Address				

Primary Insurance Information

Insurance Company Name				Insurance Co. Phone #			
Street Address			City			State	Zip
Policy #		Group #		Plan #		Date Policy Became Effective	
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent				Subscriber Social Security #			
Subscriber Name				Subscriber Date of Birth			
Subscriber Address				Subscriber Employer			

Secondary Insurance Information

Insurance Company Name				Insurance Co. Phone #			
Street Address			City			State	Zip
Policy #		Group #		Plan #		Date Policy Became Effective	
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent				Subscriber Social Security #			
Subscriber Name				Subscriber Date of Birth			
Subscriber Address				Subscriber Employer			

Emergency Contact Information

Emergency Contact Name	Relationship	Home Phone #	Work/Cell #
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Assignment of Benefits

Authorization to pay benefits to physician: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services as described.

 Signature of patient or legal guardian Date

Authorization to release information: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment to the insurance company or any other party involved in reimbursement for the claim.

 Signature of patient or legal guardian Date

For Medicare Patients Only

Lifetime Assignment of Medicare Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to the above referenced Medical Practice for services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services.

 Signature of patient or legal guardian Date

