

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____ Sex _____
(Last) (First) (Middle) (Month, Day, Year)

Home Address _____ (no P. O. Boxes, please)
(Street, Apt. #) (City) (State) (Zip)

Phone: (Include Area Code) Home # _____ Work # _____ Cell # _____

Employer _____ Soc. Sec # _____

Work Address _____
(Street) (City) (State) (Zip)

Is this a worker's compensation claim? ___ Yes ___ No If Yes, Date of Injury _____

Is your complaint due to an accident? Yes / No Type _____

Source of Referral: (Check One) ___ Self-Referral ___ Patient Referral

Referring Physician _____ Phone # _____ Fax # _____

Address: _____

Name of doctor you are seeing today: () J. Jones, M.D. () I. Cherches, M.D. () S.M. Lovitt, M.D. () G.S. McLauchlin, M.D.

Chief Complaint(s): (1) _____ (2) _____ (3) _____

Marital Status: () Single () Married () Separated () Divorced () Widowed

Emergency Contact _____ Contact phone # _____

Person responsible for payment: () Self () Other (i.e. spouse, parent, employer)

If other, name here _____ Relationship _____

Consent for Treatment _____ Date _____
(Patient's Signature)

Insurance Information

Primary Insurance

Name of Insurance Company _____ HMO _____ PPO _____

Member # or ID # _____ Group # _____

Policy Holder: Self? ___ Yes ___ No ___ Ins. Phone # (member services) _____

Name of Employer _____ Soc. Sec # _____ DOB of Policyholder _____

Occupation _____ Address _____

Secondary Insurance

Name of Insurance Company _____ HMO _____ PPO _____

Member # or ID # _____ Group # _____

Policy Holder: Self? ___ Yes ___ No ___ If other name, write name here _____

Name of Employer _____ Soc. Sec# _____ DOB of Policyholder _____

Occupation _____ Address _____

* We bill \$25.00 for Office Visits cancelled within 24 hours of the scheduled time.