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NEW PATIENT INFORMATION

Name:____

Address:____

City:_______________________________________ **State:**____**Zip:**_________

email:_____________________________**DOB:**___________________________

Home #:______________ **Work #:**______________ **Cell#:**______________________

Insurance Carrier and Phone Number:____

Policy #:_________________ **Group#**_________________ **Subscriber:**____________________

Secondary Insurance Carrier and Phone Number:_____________________________________

Policy#:__________________**Group#**_________________**Subscriber:**_____________________

Claim#(If Auto/Worker's Compensation)____

Claim Adjuster and Phone#____

Chief Complaint:____

Have you been treated for this condition before? Yes _____ No _____
If so, when?_____________. **Treating healthcare provider**______________________
Are your complaints a result of an injury?
If yes, please circle one: Automobile/Personal Injury / Workers Compensation

Do you have access to recent imaging studies/reports? Yes_____ No_____

How did you hear of our office?

Patient:_______________________ **Phone Book:**_____________________

Physician: ________________ **Insurance Company** ____________________

Internet (Circle): Google Healthgrades Yelp Other________________

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

PRINTED NAME_______________________ SIGNATURE__________________________ DATE________

I authorize you to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process my claim for reimbursement of charges incurred.

PRINTED NAME_______________________ SIGNATURE__________________________ DATE_________