Confidential Patient Information

Patient Name ________________________________ **DOB** _____/______/_____ **Age:** _____ **M**_____/**F**_____

Address ____ **Apt#** ______**SS#** ____________________________

City ____ **State** __________ **Zip Code** ______________________

Phone ___________________ **Alt. Phone** ___________________ **Email** _______________________________

Employer ___________________________________ **Occupation** _____________________________________

Address: ____**City** _________________________________

State __________ **Zip Code** _______________________**Work Phone** ____________________ **Ext** __________

Single____ **Married** ____**Divorced**____ **Widowed** ____**Emergency Contact**____________________________

Phone __________________ **Spouse** _______________________ **Referred by** _________________________

<u>CLAIM INFORMATION:</u> **Cause:** **Auto Accident** ____**Personal Injury** ____**Work Injury** ____**Other** ____

Type of Claim **Cash** ____ **Group Health** ____ **Personal Injury** ____**Worker's Comp** ____

<u>INSURANCE INFORMATION:</u> **Relationship to the Insured: Self** ____**Spouse** ____**Child** ____**Other**____

Insured's Employer (Same as Above_____**)** **Other**________________________ **Insured's SS#: (as Above**____**)**

Other SS#____________________ **Insured's DOB: (as Above**____**)** _____/______/_____

Primary Insurance Co. _____________________________**Address** ___________________________________

City _________________________**State** _____ **Zip Code** ___________ **Phone** _________________**Ext** ______

Policy #_______________________________________**Group#** ______________________________________

Secondary Insurance Co. ___________________________**Address** ___________________________________

City _________________________**State** _____ **Zip Code** ___________ **Phone** _________________**Ext** ______

Policy #_______________________________________**Group#** ______________________________________

Attorney __________________________________**Address** ____

City _________________________**State** _____ **Zip Code** ___________ **Phone** _________________**Ext** ______

<u>AUTHORIZATIONS:</u>

A. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. Additionally, I hereby authorize release of any medical information to any third party as I deem necessary for my medical benefit.

B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe to this office by my attorney, out of the proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and/or services rendered.

C. I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature ____ **Date**___________________

Guardian's Signature ____ **Date**___________________