

PLEASE PRINT ALL INFORMATION

Mr./Mrs./Ms. \_\_\_\_\_ Middle \_\_\_\_\_  
First Name \_\_\_\_\_ Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Home Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Home Telephone ( ) \_\_\_\_\_ Cellular phone ( ) \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ SSN# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Marital Status \_\_\_\_\_ S = Single, M = Married, D = Divorced, W = Widowed, X = Legally Separated Height \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Telephone ( ) \_\_\_\_\_

Name of Cardholder if other than self \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Employer & Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Home Telephone ( ) \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_  
Birthdate \_\_\_\_\_ SSN# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Please list allergies to medications:**

Employee Status:  Employed  Unemployed Date last worked \_\_\_\_\_

Type of injury:  Work  Auto\*  Other  Sports (Non-work related) **Date of injury or onset of condition** \_\_\_\_\_  
\* (complete accident report)

**Description of injury and how it happened** \_\_\_\_\_

Referred by \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Telephone ( ) \_\_\_\_\_

If Spouse, do you consent to discuss or release medical info?  yes  no

**INSURANCE INFORMATION (PLEASE INCLUDE ID'S AND GROUP #'S)**  
**\*\*PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST FOR COPYING\*\***  
**\*\*PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED\*\***

**I WILL BE PAYING BY** CASH  CHECK  CREDIT CARD

Medicare# \_\_\_\_\_ Medicaid (Public Aid)# \_\_\_\_\_  
Insurance (Primary) \_\_\_\_\_ Insurance (Secondary) \_\_\_\_\_  
Policy# \_\_\_\_\_ Policy# \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Name of Insured \_\_\_\_\_  
if other than self \_\_\_\_\_ if other than self \_\_\_\_\_  
Relationship \_\_\_\_\_ Relationship \_\_\_\_\_  
SSN# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SSN# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**\*IMPORTANT:** Some insurance companies do not cover full payment for surgery, treatment, splints, (orthotics), or therapy. In those cases, the patient will be responsible for assuming full payment for such services.

Date: \_\_\_\_\_ Signature \_\_\_\_\_

I authorize the release of medical or other information necessary to process this claim. I also request payment of benefits to the party who accepts assignment.

Date \_\_\_\_\_ Signature \_\_\_\_\_