

### Patient Information

Last name, first, middle initial		Date of Birth	Sex	Marital Status Married Divorced Single Widowed	
Street Address			Home Phone		Cell Phone
City, State, Zip Code			Work Phone		Fax Number
Email Address				Social Security Number	
Employer's Name				Drivers License Number	
Employer's Street Address				State in Which Issued	
City, State, Zip Code				Occupation	
Emergency Contact		Relationship	Religious Preference (statistical purposes only)		Race (statistical purposes only)
Street Address			Home Phone		Work Phone
Next of Kin			Home Phone		Work Phone

### Insurance Information

Primary Insurance		Secondary Insurance	
Address		Address	
Customer Service Phone Number		Customer Service Phone Number	
Policy or ID Number		Policy or ID Number	
Subscribers Name		Subscribers Name	
Relationship to Patient		Relationship to Patient	
Subscribers Employer, Address, Telephone Number		Subscribers Employer, Address, Telephone Number	
Subscribers Date Of Birth	Subscribers Social Security No.	Subscribers Date Of Birth	Subscribers Social Security No.

How did you hear about us?      Lecture \_\_\_\_\_ Friend \_\_\_\_\_ Internet \_\_\_\_\_  
Date: \_\_\_\_\_ Name: \_\_\_\_\_

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted as valid as the original.

By checking this box  I authorize "the program" to contact me by mail, phone or email.

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

**For Office Use Only:**  
Date of Physical: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_ Auth #: \_\_\_\_\_