Today's Date: _____ **Injury or Onset Date:** _____
Reason for your visit today: _____

Statistics:

Patient Name: _____
LAST FIRST M SUFFIX

Current Mailing Address:

_____
PO BOX OR STREET ADDRESS CITY STATE ZIP

Email Address: _____

Employer: _____ **Occupation:** _____

Emergency Contact: _____
NAME PHONE #

Who **referred** you to our clinic? _____

Home (____) _____

Work (____) _____

Cell (____) _____
Please indicate on the 3rd page if you would like to receive appointment reminders by text message

Date of Birth: _____

AGE: _____ **GENDER:** M / F

S.S.N.: _____ - _____ - _____
(Insurance Purposes Only)

MARITAL STATUS: M S D W

Who is responsible for this bill?

Name:_____

Phone:_____

Relationship to YOU:_____

Release of Information:

Please list any person who you wish to have access to your personal/billing information:

_____

_____

_____ INT: _____

Please Provide Us with Your Current Insurance Card

Payment Information:

Insurance Coverage? Y/N **Workmans Compensation?** Y/N **Auto Accident?** Y/N

Primary INS Co:_____ Secondary INS Co:_____
Policy ID#: _____ Policy ID#: _____
Your Relationship to the Insured: _____

Consent to Treatment - I give my consent for examination and the performance of any tests or procedures required. If patient is a minor, by signing I give consent for examination tests and procedures for the above minor patient. By signing below, I verify that the information provided is correct to the best of my knowledge.

Signature: _____ **Date:** _____