

### A. PATIENT

|                                     |          |                |                     |         |                |  |
|-------------------------------------|----------|----------------|---------------------|---------|----------------|--|
| <b>Please Print Legibly on Form</b> |          |                |                     |         | Email Address  |  |
| Last Name                           |          | First Name     |                     |         | Middle Initial |  |
| Address                             |          | Apt#           | City                | State   | Zip            |  |
| Home Phone ( )                      |          | Cell Phone ( ) |                     |         | Work Phone ( ) |  |
| Birth date                          |          | Gender         | Male                | Female  | SSN # - -      |  |
| Family Physician                    |          |                | Referring Physician |         |                |  |
| Employment Status                   | Employed | Un-Employed    | Retired             | Student | Other          |  |
| Employer Name                       |          |                |                     |         |                |  |

### B. Emergency Contact

|   |  |                  |  |  |                |  |
|---|--|------------------|--|--|----------------|--|
| Last Name   |  | First Name       |  |  | Middle Initial |  |
| Home Phone ( )  |  | Mobile Phone ( ) |  |  | Work Phone ( ) |  |
| Relationship to Patient Spouse Parent Child Grandparent Sibling Friend Other: |  |                  |  |  |                |  |

### C. GUARANTOR / RESPONSIBLE PARTY (fill out if patient is a minor)

|  |  |                  |      |        |                |  |
|--|--|------------------|------|--------|----------------|--|
| Last Name  |  | First Name       |      |        | Middle Initial |  |
| Address  |  | Apt#             | City | State  | Zip            |  |
| Home Phone ( )   |  | Mobile Phone ( ) |      |        | Work Phone ( ) |  |
| DOB (mm/dd/yy)   |  | Gender           | Male | Female | SSN # - -      |  |
| Employer   |  |                  |      |        |                |  |
| Relationship to Patient Parent Grandparent Legal Guardian Other: |  |                  |      |        |                |  |

### D. Insurance (if applicable)

|   |  |  |  |  |                |  |
|---|--|--|--|--|----------------|--|
| <b>Primary Insurance (copy of card must be on file) Check here if Name, SSN &amp; DOB same as patient</b>   |  |  |  |  |                |  |
| Insurance Name  |  |  |  |  |                |  |
| Subscriber (Insured) Name   |  |  |  |  | SSN#           |  |
| Relationship or Patient to Subscriber Self Spouse Child Other   |  |  |  |  | DOB (mm/dd/yy) |  |
| <b>Secondary Insurance (copy of card must be on file) Check here if Name, SSN &amp; DOB same as patient</b> |  |  |  |  |                |  |
| Insurance Name  |  |  |  |  |                |  |
| Subscriber (Insured) Name   |  |  |  |  | SSN#           |  |
| Relationship or Patient to Subscriber Self Spouse Child Other   |  |  |  |  | DOB (mm/dd/yy) |  |

### E. ACCIDENT (if applicable)

|  |  |      |                       |     |           |  |
|--|--|------|-----------------------|-----|-----------|--|
| <b>Work related accident? Yes No Auto or Liability/3rd Party accident? Yes No (if yes, fill out information below)</b> |  |      |                       |     |           |  |
| Auto/ Work Insurance Name  |  |      |                       |     | Phone ( ) |  |
| Address  |  | City | State                 | ZIP |           |  |
| Policy #   |  |      | Agent / Adjuster Name |     |           |  |
| Claim #  |  |      | Accident Date         |     |           |  |