Chart #________________

Date ________________

Dr. # ________________

PATIENT INFORMATION (PLEASE PRINT)

NAME: ____
(Last) (First) (Middle Initial)

ADDRESS: ____
(Street) (Apt. #) (City) (State) (Zip)

TELEPHONE: (H) ( )________________ (O) ( ) ________________

MARITAL STATUS: ________ Single ________ Married ________ Separated ________ Divorced ________ Widowed

SOCIAL SECURITY NUMBER: ________________ BIRTH DATE: ________________
(mo) (day) (yr.)

DRIVERS LICENSE # ________________ EXPIRATION DATE: ________________

AGE: ________

PATIENT'S EMPLOYER: ________________________________

EMPLOYER'S ADDRESS: ________________________________

REFERRING PHYSICIAN: ________________ PHONE: ( ) ________________

REASON FOR VISIT: ________________________________

PRIMARY CARE PHYSICIAN: ________________ PHONE: ( ) ________________

EMERGENCY CONTACT (NAME): ________________________________

ADDRESS: ________________________________ PHONE: ( ) ________________
(Street) (City) (State) (Zip)

RESPONSIBLE PARTY: (If you check "Self", proceed to insurance information on reverse side)

________ Self ________ Spouse ________ Parent ________ Other ________________
(Relationship)

NAME: ________________________________

ADDRESS: ________________________________ PHONE: ( ) ________________

ARE YOU A RESIDENT AT A NURSING HOME? ☐ YES ☐ NO

IF YES, WHICH ONE? ________________________________

Be Sure to Complete Insurance Information on the Next Page!

018

INSURANCE INFORMATION (PLEASE PRINT)

PRIMARY: (If the policyholder is other than the patient, please put policyholder's full name, employer & date of birth)

POLICYHOLDER NAME: ______________________________

POLICYHOLDER DATE OF BIRTH: ______________________________

POLICYHOLDER'S EMPLOYER: ______________________________

SOCIAL SECURITY NUMBER (or I.D.#): ______________________________

RELATIONSHIP TO THE INSURED: ______________________________

INSURANCE COMPANY NAME: ______________________________

ADDRESS: ______________________________

MEDICARE/POLICY NUMBER: ______________ GROUP NUMBER: ______________

SECONDARY: (If the policyholder is other than the patient, please put policyholder's full name, employer & date of birth)

POLICYHOLDER NAME: ______________________________

POLICYHOLDER DATE OF BIRTH: ______________________________

POLICYHOLDER'S EMPLOYER: ______________________________

SOCIAL SECURITY NUMBER (or I.D.#): ______________________________

RELATIONSHIP TO THE INSURED: ______________________________

INSURANCE COMPANY NAME: ______________________________

ADDRESS: ______________________________

MEDICARE/POLICY NUMBER: ______________ GROUP NUMBER: ______________

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ______________________________ Date ______________