OFFICE USE ONLY
Patient No.:____________
Date: _________________

INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **(PLEASE PRINT)**

First Name_______________________ M.I. ___ Last Name _______________________________ Sex: M F

Home Phone ___________________ Work Phone __________________ Cell Phone _____________________

E-Mail Address ____

Address ________________________________ City ___________________ State ________ Zip __________

Birth date ____________________ Age _____ Marital Status: S M W D Number of Children _____

Driver's License # __________________ Social Security # _______________________

Your Employer ______________________________ Occupation ____________________Years On Job ____

Employer Address _____________________________ City _____________________ State _____ Zip ______

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____

Insurance Company _____________________________ Insured's Name: ______________________________

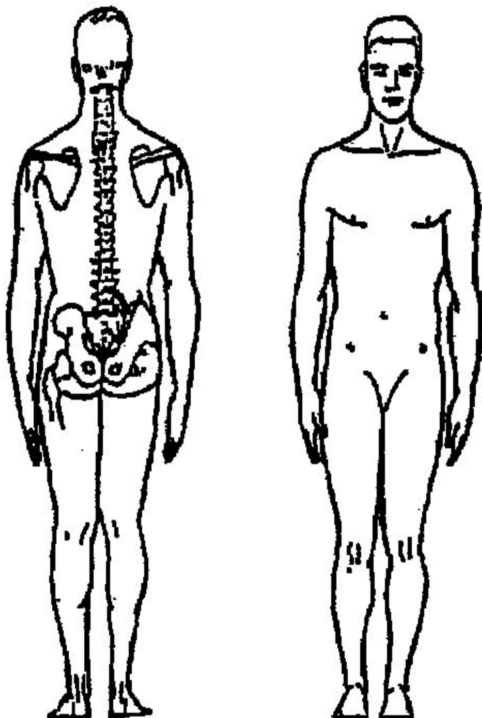
Relationship: _______________ Insured's Birth date: _______________ Insured's SS#: __________________

Insured Employed By: _______________________________ Occupation: _____________________________

Employer Address ________________________________ City ____________________ State _____

Zip ____________ Office Phone # ___________________ Years On Job _____

Does your spouse have health insurance at work? Yes _____ No _____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, constant, off & on, when standing, when sitting, etc………

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

____
____
____
____
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____
____
____

(TURN OVER)

Whom may we thank for referring you to our office?
____

How payment will be made: Type of Insurance: _________________________

__________ Cash __________ Worker's Comp. __________Health Insurance
__________ Check __________ Credit Card __________Automobile Insurance Policy

Is your condition due to an accident? Yes _____ No _____ Date of accident? ____________________
Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____________________
Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature ____ Date ______________________
Or Guardian Signature _______________________________________ Date ______________________

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

Authorization for email communication

Printed Name: ____ **Date:** _________________

Printed Email address: ____

Signature: ____

Please be aware that you can opt out for email communication at any time.

(TURN OVER)