PATIENT INFORMATION

Patient's Name: Last_________________________ First _______________________Middle___________

Social Security #:______-_____-______ Male ____ Female ____ Date of Birth _____/_____/_____

Address: ____

City/State/Zip: ____

Phone #: Daytime (____) _____-_______ Evening (____) _____-_______ Cell (____) _____-________

E-mail address: ____

Physician requesting exam: _____________________ other physician to receive report: _______________

SEASONAL RESIDENTS – PLEASE PROVIDE YOUR PERMANENT ADDRESS:

Address: ____

City/State/Zip: ____

Phone #: Daytime (____) _____-_______ Evening (____) _____-_______ Cell (____) _____-__________

DO YOU (the patient) CURRENTLY RESIDE IN A SKILLED NURSING FACILITY? ☐ Yes ☐ No

If yes, please provide the name and phone number of the facility.

Facility Name: ____ Phone #: (_____) ______-_________

PRIMARY LANGUAGE: ____

PERSON TO NOTIFY IN CASE OF EMERGENCY: ____

Phone #: (_______)_________________________ Relationship: ___________________________

EMPLOYMENT INFORMATION

Are you (circle one) Employed Unemployed Retired Student

Employer Name: ____

Employer Address: ____

Responsible Party Information

Responsible Party Name: Last _______________________First _____________________Middle________

Patient Relationship to Responsible Party: ____

Sex: M F Date of Birth: _____/_____/_______ Social Security #: ______-_____-______

Address ____ Apt.#: ______________________

City/State/Zip: ____

Phone@: Home (_____) _____-______ Work (______) _______-________ Cell (_____) _____ - ______

Responsible Party Employer: ____

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REFERRING PHYSICIAN

Physician requesting today's exam: ____

Other physician(s) to receive report: ____

Are we billing insurance for today's visit? Yes____________ No ________________

Primary Insurance (*provide your insurance card to the front desk at check- in*)

Name of Policyholder: __________________________ Patient Relationship to Insured: ______________

Policyholder date of birth: _____/_____/_____ Policyholder Social Security #: ______-_____-________

Insurance Company Name: ____________________________________ Phone#: (____) _____-_______

Insurance Company Address: ____

Policy #: __________________________ Group#: ____________________ Claim#: ________________

Effective date: _____/_____/_____ Accident or Injury Date: ______/______/______

Is this coverage through the policy holder's employment? Yes ______ No_____

If yes, name of employer: ____

Is this an Auto Accident? ☐ Yes ☐ No

Is this a Worker's Compensation claim: ☐ Yes ☐ No

Adjustor: _______________________________________ Adjustor phone#: (____) _____-_______

***** You must notify your auto insurance adjuster of your motor vehicle accident for the claim to be processed. Failure to do so makes you personally responsible for your changes.***

Is an attorney involved? ☐ Yes ☐ No

Attorney Name: ____ Phone: (____) _____-_______

Address: ____ City/State/Zip: __________________________

Secondary Insurance Information (*provide your insurance card to the front desk at check- in*)

Name of Policyholder: ___________________________ Patient Relationship to Insured: _____________

Policyholder date of birth: _____/_____/_____ Policyholder Social Security #: ______-_____-________

Insurance Company Name: _____________________________________ Phone#: (____) _____-______

Insurance Company Address: ____

Policy #: ___________________________ Group#: __________________ Claim#: _________________

Effective date: ______/______/______

Is this coverage through the policy holder's employment? Yes _____ No ______

If yes, name of employer: ____