Patient Name: ____ **M F** **Marital Status:** S M D W

Address: ____ ________________________ ________
Street City / State Zip

Phone: (Home) ____________________ **(Cell)** _______________________

SS#: _____-_____-_____ **Date of Birth:** ________________ **Driver's License:** ________________________

Employer: ___________________________ **(Work Phone)** _____________ **Occupation:** _______________

Employer Address: _____________________________ ___________________________ ___________
Street City / State Zip

Emergency Contact: __________________________________ **Emergency Phone:** _____________________

Referring MD: ____________________________ **Primary Physician:** _____________________________

Diagnosis: ____ **Injury/Onset Date:** ____________________

How did you learn about us: **Physician** **Medical Directory** **Yellow Pages** **Internet**

Former Patient **Postcard** **Sponsored Event**

Insurance Policy Holder: Self / Other: _______________________________ **Insured DOB** ____________

Relationship to patient: Spouse / Parent / Other:_____________ **Insured SS#** _______-______-________

Insured's Employer: ____

<u>**Primary:**</u> ☐ **Automobile (PIP)** ☐ **Workman's Compensation** ☐ **Medicare** ☐ **Commercial Insurance**

Insurance Name: _____________________________ **ID / Claim #** ___________________ **Group** ____________

Address: ____ ____________________________ _________

Phone: _____________________________ **Extension:** _________ **Adjuster:** ___________________________

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<u>**Secondary:**</u> ☐ **Automobile (PIP)** ☐ **Workman's Compensation** ☐ **Medicare** ☐ **Commercial Insurance**

Insurance Name: _____________________________ **ID / Claim #** ___________________ **Group** ____________

Address: ____ ____________________________ _________

Phone: _____________________________ **Extension:** _________ **Adjuster:** ___________________________

I have reviewed the above information, other than any changes indicated above, I found the information to be correct. I have been informed of the above coverage verified and understand that this is only a verbal verification of benefits, NOT a guarantee of payment by my insurance company. This is NOT a guarantee of payment. We encourage you to independently verify you own insurance.

Patient Signature: ____ **Date:** ______________________