PATIENT BASIC INFORMATION

PERSONAL INFORMATION

Last Name:	First Name:	Mid. Init.:
Address:	City, State, Zip**:**	
Home Phone:	Work Phone:	
Date of Birth:	**Social Security No:**	
Occupation:	Employer:	
Sex: M F	Marital Status: Single Married Divorced	
Employment Status: EMPLOYED Full time/Part time STUDENT Full time/Part time		
Dominant Hand: R L Both	Date of Injury/Onset:	

INSURANCE INFORMATION

Insurance Company:	**Phone Number on Insurance Card:**
Policy Number:	**Claim/Group Number:**
Relation to Insured: Self Husband Wife Parent Child Other	

AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT

A. AUTHORIZATION FOR RELEASE OF INFORMATION:
It is understood that the record of this treatment may be disclosed when requested to do so by the named company/companies or their representatives.

B. GUARANTEE OF ACCOUNT:
I fully understand I am financially responsible for charges not covered by this authorization.

C. ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize payment of the benefits otherwise payable to me, by the designated insurance company/companies directly to this office.

D. AUTHORIZATION:
I hereby authorize the release of reports and information pertaining to my condition/treatment for comparison with current examination.

PATIENT SIGNATURE: _____ DATE: _____