PRIMARY [redacted] DR. _____, _____
LAST NAME FIRST NAME

_____
STREET ADDRESS

_____, _____, _____
CITY STATE ZIP CODE

NAME _____

SOCIAL SECURITY NO. _____ AGE: _____

_____ ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
BIRTH DATE

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____

EMAIL ADDRESS _____

PARENT'S / SPOUSE'S NAME _____

EMPLOYED BY _____

CITY _____ STATE _____ ZIP _____

WK PHONE _____ OCCUPATION _____

NAME _____ PHONE _____
PERSON RESPONSIBLE FOR PAYMENT

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Do you receive worker's compensation benefits? YES / NO

Is this treatment for an injury or illness covered under auto no-fault ins. or for which another party is liable? YES / NO

I am aware that unless an appointment is cancelled 24 hours in advance a charge will be made.

I hereby accept responsibility for any patient balance, copay & / or deductibles which my insurance require.

X_____ DATE_____
SIGNATURE

S-206726