

DATE _____ / _____ / _____

REFERRED BY _____
PRIMARY CARE PHYSICIAN _____

PATIENT INFORMATION (Please Print)

GENERAL INFORMATION

PATIENT'S FIRST NAME			MIDDLE INITIAL	LAST NAME			BIRTHDATE			
PATIENT'S ADDRESS (IF MAILING ADDRESS IS PO BOX, STREET ADDRESS REQUIRED ALSO)							SEX	AGE	<input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED
CITY							M	F	<input type="checkbox"/> MARRIED	<input type="checkbox"/> WIDOWED
STATE			ZIP CODE			PATIENT'S SOCIAL SECURITY NUMBER				
PATIENT'S PHONE			CELL PHONE			PATIENT'S EMPLOYER				
EMPLOYER PHONE NUMBER			OCCUPATION			PATIENT'S SOCIAL SECURITY NUMBER				

SPOUSE, GUARDIAN OR RESPONSIBLE PARTY INFORMATION

FIRST NAME			MIDDLE INITIAL	LAST NAME			BIRTHDATE		RELATIONSHIP TO PATIENT
EMPLOYER							SPOUSE'S SOCIAL SECURITY NUMBER		
HOME PHONE NUMBER			CELL PHONE NUMBER			WORK PHONE NUMBER			

NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU (ALTERNATE CONTACT REQUIRED)

NAME			RELATIONSHIP			PHONE NUMBER		
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PRIMARY HEALTH INSURANCE

INSURANCE CO.						SUBSCRIBER		
CLAIM BILLING ADDRESS						EMPLOYER		
INS. PHONE NUMBER		GROUP #		I.D. #		CO-PAY		

SECONDARY HEALTH INSURANCE

INSURANCE CO.						SUBSCRIBER		
CLAIM BILLING ADDRESS						EMPLOYER		
INS. PHONE NUMBER		GROUP #		I.D. #				

ACCIDENT

IS THIS AN ON-THE-JOB INJURY, AUTOMOBILE, OR HOUSEHOLD ACCIDENT?						INS. CARRIER		
HOW DID INJURY OCCUR?						CLAIM NUMBER		
DATE OF INJURY			IF UNABLE TO WORK, DATE LAST WORKED			ADJUSTER'S NAME		
WHERE DID INJURY OCCUR? <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> OTHER: EXPLAIN						ADJUSTER'S PHONE NUMBER		
PREVIOUS DOCTORS SEEN FOR THIS INJURY						CLAIMS ADDRESS		

_____ INITIAL HERE IF YOU WOULD LIKE TO BE ON OUR MAILING LIST

Assignment and release: I hereby assign my insurance benefits to be paid directly to Edwin N. Austin, M.D. I understand that I am financially responsible for non-covered services. I also authorize Dr. Austin and staff to release any information required to process this claim. I also consent to medical photography and authorize release for medically related purposes.

Signed _____ Date _____