

Date of Service	Appt Time	ID	Acct#
Procedure Ordered			
Last Name	First	MI	Gender: M F
SSN	DOB	Marital Status	
Address 1			
Address 2			
City	State	Zip	
Day Phone (    )		Evening Phone (    )	

### Responsible Party

Last Name	First	MI
SSN	DOB	
Relationship		
Address		
City	State	Zip

### Emergency Contact

Name
Relationship
Phone

### Employer

Employer Name		
Address		Phone
City	State	Zip

### Injury

Date of Injury
Type
Claim #

How did you hear about us? Physician Referral  TV  Radio  Other

**Billing Information**  Self Pay  Insurance  Direct Bill

Payer Name		Plan Name	
Address			
City	State	Zip	Phone
Subscriber relationship		Last	First MI
DOB	Policy#	Group#	

Payer Name		Plan Name	
Address			
City	State	Zip	Phone
Subscriber relationship		Last	First MI
DOB	Policy#	Group#	

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I also understand that if my balance is not paid in a timely manner, it could also incur reasonable collection fees. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I authorize release of my medical information to my referring physician via facsimile.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_