PATIENT INTRODUCTION FORM

Today's Date: _____

Last Name:	**MI:** **First Name:**	
Home Address:	**City:** **State:** **Zip:**	
Phone: Home:	**Cell:**	
Work Phone:	**Can we contact you at work ☐ Yes ☐ No**	
Email:		
Who Referred You to Our Office:		
Date Birth: Age:	Social Security No:	
Employer's Name:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed	
Occupation:	Name of Family Physician:	

THIS VISIT IS RELATED TO:

☐ Motor Vehicle Collision Injury ☐ Preventative/Wellness Care ☐ Sport / Recreational Injury
☐ Non-Injury Pain/Symptoms ☐ Weight Loss Program ☐ Home Injury Symptoms
☐ Work Related Injury/Symptoms ☐ School Physical ☐ Chronic Pain
☐ Describe Others:

HEALTH-MEDICAL INSURANCE INFORMATION

Primary Health Insurance Information

Please present your insurance card to the front desk person.

Insurance Name: _____
Address: _____
Telephone:

You are: ☐ The Insured ☐ A Dependent

Name of Insured Person: _____
Address: _____ City: _____ Zip: _____
Social Security Number: _____ Insured Date of Birth: _____
Name of Insured Employer:_____

Secondary Health Insurance Information

Please present your secondary insurance card to the front desk person.

You are: ☐ The Insured ☐ A Dependent

Insurance Name: _____
Address: _____
Telephone:

☐ Insured, ☐ Dependent

Name of Insured Person: _____
Address: _____ City: _____ Zip: _____
Social Security Number: _____ Insured Date of Birth: _____
Name of Insured Employer:_____

Please Complete Other Side

AUTOMOBILE INSURANCE INFORMATION

(Only fill this portion if you were involved in a vehicular accident)

Do you or someone else have insurance coverage for the vehicle you were in?	☐ I have, ☐ Someone else has coverage. Indicate name of person policy is under:
How is this person related to you	☐ Self, ☐ Spouse, ☐ Parent, ☐ Friend, ☐ Other
Name of your Automobile Insurance Carrier:	
Address of your Automobile Insurance Carrier:	
Claim Adjusters Name/Telephone Number:	Name: Telephone (area code):
Claim Number:	
Do you have an Insurance Deductible?	☐ Yes, ☐ No Deductible is: $
Do you know your Policy Limits for medical bills?	☐ Yes, ☐ No Limit is: $
Have you reported this injury to your insurance carrier?	☐ Yes, ☐ No

Do you have an attorney representing you? ☐ Yes ☐ No If yes, indicate name and address:	Attorney Name: _____ Address: _____ Telephone:

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):
Name: _____
Relationship: _____
Telephone: _____

IF APPLICABLE OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES FOR YOU AS A COURTESY. HOWEVER, IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS.

_____ _____ Patient/Guardian Signature Date	I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health and/or automobile insurance carrier(s). I understand that all account balances over 30 days old are subject to a 1.5% monthly interest charge. I also agree that in the event collection procedures are needed, all cost for collection fees and/or attorney fees will be added to the cost of the services rendered, and will become part of the judgment. Minors must have parent or guardian's signature.