Name_____

Address_____

City/State/Zip_____

Telephone Home _____

Work _____

Cell _____

E-mail _____

Are there any restrictions on how we contact you?

_____

Male / female Age_____

Date of Birth_____

SS#_____

Marital Status - single / married/ divorced/ other_____

ReferringPhysician_____

Primary Care Physician_____

Referred by other source (name)_____

Pharmacy_____

Employed/ Retired / Full- time student/ other_____

Employer_____

Address_____

City/State/Zip_____

Emergency Contact

Name_____

Telephone__

Relationship_

If being seen for an injury, date of accident_____

Claim number_____

Workers Comp Carrier_____

Attorney (if involved in the case)_____

INSURANCE SUBSCRIBER - same as patient ( )

Name_____

Address_____

City/State/Zip_____

Telephone_____

SS#_____

SUBSCRIBER'S EMPLOYMENT (if other than patient)

Employer_____

Address_____

City/State/Zip_____

Subscriber's relationship to patient_____

PRIMARY INSURANCE

Carrier_____

Insured ID number_____

Group Policy number_____

SECONDARY INSURANCE

Carrier_____

Insured ID number_____

Group Policy number_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment directly to Dr Poulos of medical/surgical benefits, if any, otherwise payable to me for her services.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the above named physician to release any information acquired in the course of my examination or treatment that is required to process my insurance claim.

Patient's signature agreeing to the authorizations at left

(Or parent/guardian if the patient is a minor)

_____ _____

Name date

Let us know the concern or problem that brought you here-

_____

_____

_____