Patient Information

Name_____ Date _____
Last First MI

Address_____ City _____ State _____ Zip_____

Phone# Home:_____ Cell:_____ May we leave a message?_____

Email:_____ Preferred communication: Phone / Email / Mail

Soc. Security# _____ Birth Date_____ Age_____ Sex: F or M

Smoking Status: Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Marital Status_____ Spouse's Name _____

Employer_____ Occupation_____

Employer Address_____ Phone # _____

City _____State _____Zip_____ May we contact you at work? Yes / No

Full or Part Time Employment _____

Who is responsible for the account? _____

Insured's Name_____ Soc. Security # _____

Insurance Co. _____Group # _____

Is the insured covered by additional insurance? Yes / No

Insurance Co. _____Group # _____

Relationship to insured: __Self __Spouse __Child __Other

Is condition due to an accident? No / Yes Date of accident_____ Type of accident: Auto / Work / Home / Other _____ To whom have you reported the accident? Auto Ins. / Employer / Workers Comp. Attorneys Name (if applicable) _____

IN CASE OF AN EMERGENCY, CONTACT:

Name_____

Relationship_____ Home Phone _____Work Phone_____

Name of your Medical Physician _____

My Medical Physician practices at (Hospital/Clinic) _____

Whom may we thank for referring you to us? _____

ASSIGMNEMT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named insurance company and assign directly to Dr. Rebecca A. Studelska all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signed _____ Date _____