



CONFIDENTIAL PATIENT INFORMATION

Please fill out completely and accurately

Name: (Last) _____ (First) _____ (MI) _____ Sex: F M
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone: _____ H W C Secondary Phone: _____ H W C
Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____ Marital Status: S M
Employer: _____ Email Address: _____
Nearest Relative/Emergency Contact: _____ Phone: _____

Referring Physician: _____ Practice: _____
Physician Phone: _____ Physician Fax: _____ Date of Next Visit: _____
Diagnosis or description of problem: _____ Date of Onset: ____ / ____ / ____

Is this treatment for: Automobile Accident _____ Worker's Compensation _____ Claim Number: _____
Insurance Company: _____ Adjuster/Case Manager: _____
Insurance Phone: _____ Insurance Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

How did you choose our practice? (Check all that apply): Physician Referral _____ Friend/Relative (name) _____
Insurance Company _____ Yellow Pages _____ Internet Search _____ Newspaper Ad _____ Other (list) _____

Name of Responsible Party: _____ Relationship to Patient: _____
Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Please present your insurance card to the office staff for photocopying.

Patient's Primary Medical Insurance: _____
Subscriber Name: _____ Date of Birth: ____ / ____ / ____
Relation to Patient: _____ Policy/Member #: _____ Group #: _____
Patient's Secondary Medical Insurance (if applicable): _____
Subscriber Name: _____ Date of Birth: ____ / ____ / ____
Relation to Patient: _____ Policy/Member #: _____ Group #: _____

I authorize Advanced Physical Medicine Center to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Advanced Physical Medicine Center. I authorize Advanced Physical Medicine Center to release medical or other information necessary to process this claim.

Patient Signature _____ **Date** _____
(If patient is under 18 years of age, a parent or guardian must sign)

Please indicate method of payment (Deductible, co-pay, co-insurance): Cash _____ Check _____ Credit Card (Visa/MC) _____

- I acknowledge that I have reviewed a copy of the Notice of Privacy Practices for Advanced Physical Medicine Center regarding privacy of personal health information.
- I authorize release of medical records and x-rays from any physician or medical facility necessary and related to my medical treatment to Advanced Physical Medicine Center.
- I verify that the above information is complete, current, and correct.

Patient Signature _____ **Printed Name** _____ **Date** _____
(If patient is under 18 years of age, a parent or guardian must sign)