Patient's Name:	Sex		Date of Birth MO DY YR			Marital Status
_____	M	F				S M W D
In Case of Emergency Contact:					Phone Number:	

Patient's Address			
	Town:		Zip:
	Home Phone Number:	Work Phone Number:	E mail address:
Employer Information	Employer Name:		
	Address:		
	Who Is Responsible For This Account:		Phone Contact:
Payments To Be Made By	Cash	Personal Check	Insurance
	Primary Insurance	Name	Policy Number
	Secondary Insurance	Name	Policy Number

Insurance Information: Group_____ Private_____ Work/Comp_____ Auto_____		Policy #_____
Name of Policy Holder:	Relationship to Patient:	
Policy Holder Date of Birth:	Group Number:	

Major Complaint:
Is This Condition Due To An: Auto Accident Work Injury Injury Unknown Cause Illness
Are The Symptoms: 1) Improving 2)Getting Worse 3)Same 4)Come and Go
Date the Symptoms Appeared:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on indebtedness together with collection costs and reasonable attorney fees as may be requested to effect collection.

Patient's Signature:_____ Date:_____