

Appointment Date: \_\_\_\_\_ Doctor: \_\_\_\_\_ CHB MR #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ M \_\_\_ F \_\_\_ DOB \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (Town) (State) (Zip)

**Home Phone:** \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Patient's Primary Care Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

PERSON RESPONSIBLE FOR OUTSTANDING BILLS NOT COVERED BY INSURANCE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

INSURANCE INFORMATION

\*\*If your insurance requires a referral number, it should be obtained prior to your visit\*\*  
\*\*If we do not have the referral, you will be required to pay a \$50 deposit and you will be responsible for the bill"

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Policy/ID # \_\_\_\_\_ Group # \_\_\_\_\_

Claims Address: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Policy/ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Is visit related to accident or injury? Yes \_\_\_ No \_\_\_ If yes, please complete below.

INSURANCE INFORMATION FOR ACCIDENTS OR INJURY

Type of accident: Motor Vehicle \_\_\_ Worker's Compensation \_\_\_ Other \_\_\_

Date of accident: \_\_\_\_\_ Body Part Injured: \_\_\_\_\_

Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Claim # \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

LAWYER INFORMATION

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_