

PATIENT INFORMATION QUESTIONNAIRE

(PLEASE ANSWER ALL QUESTIONS)

DATE: _____

PATIENT INFORMATION

LAST NAME, FIRST NAME, MIDDLE INITIAL		
ADDRESS		
CITY, STATE, ZIP CODE		
HOME PHONE		WORK PHONE
GENDER (CIRCLE)	M	F
BIRTHDATE		
AGE		
SOCIAL SECURITY NUMBER		
MARITAL STATUS (CIRCLE)	SINGLE	MARRIED WIDOWED DIVORCED

IN CASE OF EMERGENCY

WHO SHOULD WE CONTACT?	Name
	Address
	Phone

	Referring Physician	Primary Care Physician
NAME		
ADDRESS		
TELEPHONE		

Reason for today's visit: _____

Is this visit related to: (Circle) 1. Work Injury 2. Auto Accident

Date of Injury: _____ Location of Injury _____ (i.e. back, knee, foot)

Is there a litigation in process related to this injury?

INSURANCE INFORMATION		
INSURANCE COMPANY NAME	PRIMARY INSURANCE	SECONDARY INSURANCE
SUBSCRIBER NAME		
SUBSCRIBER SOCIAL SECURITY NUMBER		
SUBSCRIBER DATE OF BIRTH		
Subscriber's Employer		
Employer Address		
Employer Phone Number		
Group Plan Number		
Policy Contract Number		
Effective Date		
Do you have office visit coverage?		
If so, is a referral required?		
Do you have a co-pay?		
Is a referral required for surgery?		

I understand that my doctor may not participate with my insurance and that I will be responsible for any and all charges incurred in the office and that payment is requested at the time of my visit. I authorize any holder of medical or other information about me to release such information as necessary to process these claims or related medical slaims. I permit a copy of this authorization to be used in place of the original. The doctors listed are independent practitioners and have separate professional corporations.

Date: _____

Signed: _____