Welcome To Our Office!

Name: ____ Today's Date: ____________________
First Middle Last

Home Address: ____

City: ________________________ State: __________ Zip: ______________

Telephone: ( ) __________________ Birthdate: ________________ Age: _______

Occupation: ___________________________________ SSN: ___________________________

Employer: ____ Years There: ____________
Employer's Address: ____
City: ________________________ State: __________ Zip: ______________
Work Phone: ( ) _______________________ Extension: ______________________

Cell Phone: ( ) ______________________ Cell Phone Holder's Name: _______________
***If Different From Patient** : Relationship To Patient: ______________________________

Complete this section if the insurance holder is different than patient:

Responsible Party: ___________________________________ Relationship to Patient: ________
Home Address: ____
City: ________________________ State: __________ Zip: ______________
Telephone: ( ) ______________________ Birthdate: __________________ Age: ________
Occupation: ____ SSN: _______________________
Employer: ____ Years There: ____________
Employer's Address: ____
City: ________________________ State: __________ Zip: ______________
Work Phone: ( ) _____________________________ Ext: ______________________________

In case of emergency, contact: _________________________________ Relationship: __________

Home Phone: ( ) _________________________ Work Phone: ( ) ____________________

Cell: ( ) ___________________________________ Pager: ( ) _________________________

How did you learn about our practice? ____

Primary Care Physician's Full Name: ____
Phone Number: ____________________________ ***Fax Number:*** ______________________

Patient's Name:______________________________ Today's Date:__________
First Middle Last

[Primary Insurance]

Name of Insurance Company: ____________________________________

Insured's Name: ____________________ Relationship to Insured: Self Spouse Child Other

[Secondary Insurance]

Name of Insurance Company: ____________________________________

Insured's Name: ____________________ Relationship to Insured: Self Spouse Child Other

Did your injury happen on the job? Yes No

If yes, on what date did the injury occur? ____________________

Did you report the accident to your employer? Yes No

Chief Complaint

Why are you seeing the doctor today? ____________________________________

Current problem is a result of a(n): **Check** all that apply

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other

Explain:

____
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Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. **Please remember that you are responsible for all deductibles, co-pay's and non-covered service amounts.**

I authorize the release of any medical information necessary to process my claims. I authorize payment of medical and/or surgical benefits to Bryan R. Parry, MD. **I understand** that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

Signature: ________________________________ Date: __________________