

Welcome To Our Office!

Name: _____ Today's Date: _____
First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell Phone: _____

SSN: _____ Date Of Birth: _____ Age: _____

Employment Information:

Occupation: _____

Employer: _____ Years There: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: () _____ Extension: _____

How did you learn about our practice? _____

Primary Care Physician's Full Name: _____

Phone Number: _____ **Fax Number:** _____

Complete this section if the insurance holder is different than patient: ***Parent's Information if child is a minor: *******

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: () _____ **Cell:** () _____

Insurance Information

[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:

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.

Patient Signature (If Patient Is A Minor Parents/Legal Guardian Signature):

Today's Date: _____