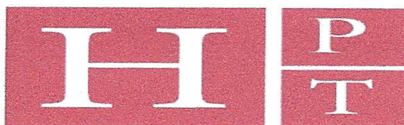

Last Name ____________________ **First Name** ____________________ **MI** ______ **SS #** ______-______-________

Address ________________________________ **City** ___________________ **State** ____ **Zip** ________ **Sex: M F**

Birthdate ____/_____/________ **Martial Status M S O Home Phone #** _______-_______-_______

Mobile # ________-________-_________ **E-mail** ____

Occupation _________________ **Employer's Name** __________________ **Work #** ______-______-_________

Body Part Injured _____________________ **Onset Date** _______/_______/_______

Doctor _____________________ **Phone #** ________-________-__________ **Fax** _______-_______-_________

Is Your Condition Related to: Work: Y N Auto Accident: Y N

Are You Missing Work as a Result of this injury? Y N (if yes, since when: _______/_________/________

Hospitalized for this Injury Y N (if yes, when: _______/_________/_______

Relationship: Self Spouse Child Other

Primary Insurance __________________ **Type: PPO POS WC Phone #** ________-________-__________

ID# _______________________________ **Group #** ___________________________

WC Claim # __________________ **Adjuster** __________________ **Phone #** ________-________-__________

Insured's Name _____________________ **DOB** _____/_____/______ **SS#** _________-______-________ **Sex: M F**

Address ________________________________ **City** ___________________ **State** ______ **Zip** ___________

Phone # _______-_______-_________ **Employer's Name** ________________ **Phone #** _______-_______-________

Relationship: Self Spouse Child Other

Secondary Insurance ____________________ **Phone #** ________-________-__________

ID # _____________________________ **Group #** ___________________________

Insured's Name _________________________ **DOB** ______/______/______ **SS#** ________-_______-________

Employer ______________________________ **Phone #** _________-_________-__________

Emergency Contact ________________________________ **Phone #** _________-_________-__________

How did you hear about us? Advertisement Doctor Family Friend Insurance

I authorize the release of any medical or other information necessary to process claims and secure payment of benefits.
I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient/Authorized Person ________________________________ **Date** ______/______/______