

**Employment Information**

Business Name: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_  
Business Address: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_  
Business Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Type of Work: \_\_\_\_\_

**Insurance Information:**

Who Is Responsible For Your Bill?  YOU and... (mark appropriate box(es))  Myself ONLY  
 Spouse  Worker's Comp  Auto Insurance  Medicare  Medicaid  Other (be specific): \_\_\_\_\_  
Personal Health Insurance Carrier: \_\_\_\_\_ Health ID Card #: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Workers Compensation Injury / Auto / Personal Injury:**

Have you filed an injury report with your employer?  Yes  No Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_ am/pm  
Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_  
Carriers Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Adjuster: \_\_\_\_\_  
Claim #: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to treat my condition as he or she deems appropriate. I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Consent to treat a Minor: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian or Spouse's Signature of Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please List your Primary Care Physician

Doctor: \_\_\_\_\_  
City, State: \_\_\_\_\_  
Phone #: \_\_\_\_\_