Name: ____

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Email Address: ____

Home Address: ______________________ City ______________ Zip Code: ________

Spouse's Name: ______________________ Work Phone: ______________________

Social Security #: ______________________ Date of Birth: ______________________

Nearest Relative Not Living With You: ______________________ Phone: ______________

Nearest Friend Not Living With You: ______________________ Phone: ______________

Primary Care or Referring Physician: ______________________ Phone: ______________

Doctor: ______________________________________ Phone: ______________

Whom May We Contact in Case of an Emergency? ______________ Phone: ______________

Whom May We Thank for Referring You to Us? ______________ Phone: ______________

Did you sustain an injury at work?

Y N

Are your injuries accident related?

Y N

Are you currently employed?

Y N

Have you ever served in the military?

Y N

Are you covered under an employer or union policy?

Y N

Is your spouse or other family member employed?

Y N

Do you have a secondary insurance policy?

Y N

Are you covered under any other health care plan?

Y N

Have you made any changes to your choice of Medicare options in the last open enrollment period?

Y N

I am a new patient to this practice and am in a preexisting provision with my insurance carrier.

Y N

Who is responsible for this bill? ____

Only fill in the following if you are diabetic:

Please circle one

Are you diabetic? ______________________ If so, are you Type 1 or Type II

Doctor who treats diabetes:____

In what city is this doctor located:____

Only fill in the following if you are an amputee:

Date of Amputation: ____

Surgeon who performed amputation: ____

Hospital where amputation took place: ____

Physical Therapist: ____

Where did you have inpatient rehab? ____

I have received services by another provider for the condition for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: ______________________________________ Date: _________________________