

**GENERAL INFORMATION**

CASE NO. \_\_\_\_\_ DATE \_\_\_\_\_  
NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
TELEPHONE \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_  
EMAIL \_\_\_\_\_  
MARRIED ( ) SINGLE ( ) DIVORCED ( ) WIDOWED ( ) CHILDREN ( )

**HEALTH INSURANCE INFORMATION**

IS THIS OR WILL THIS BE A WORKERS' COMPENSATION CLAIM? \_\_\_\_\_  
CLAIM # \_\_\_\_\_  
NAME OF HEALTH INSURANCE COMPANY \_\_\_\_\_  
SUBSCRIBER'S NAME \_\_\_\_\_  
SUBSCRIBER'S BIRTHDATE \_\_\_\_\_  
SUBSCRIBER'S RELATIONSHIP TO YOU \_\_\_\_\_  
IDENTIFICATION # \_\_\_\_\_  
GROUP # \_\_\_\_\_  
SUBSCRIBER'S EMPLOYER \_\_\_\_\_  
PATIENT'S SOCIAL SECURITY NUMBER \_\_\_\_\_ (IF DIFFERENT FROM SUBSCRIBER)  
DOES YOUR INSURANCE REQUIRE PRE-AUTHORIZATION OR A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN? \_\_\_\_\_

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_