

YOUR MEDICAL RECORDS WILL BE RETAINED FOR NO LONGER THAN 7 YEARS

SIGNATURE of Responsible Party _____ **Relationship** _____ **Date** _____

I authorize my provider and those acting on their behalf to release any medical information regarding my treatment in this practice in accordance with the HIPPA notice I have been provided, and further, to:

Name: _____ Relationship _____ Date _____

Name: _____ Relationship _____ Date _____

WORKER'S COMPENSATION OR ACCIDENT RELATED INJURY

Compensation Provider Name: _____ Adjuster's Name: _____

Address: _____ Phone #: _____

City, State, Zip: _____ Fax #: _____

Claim #: _____ Date of Injury: _____

Employer at Time of Injury: _____

PRIMARY INSURANCE

Insurance Company

Name: _____

ID #: _____ Group/Policy #: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Social Security # (REQUIRED): _____ Subscriber's Date of Birth: _____

Subscriber's Phone #: _____ Subscriber's Employer: _____

RESPONSIBLE PARTY (If Patient is Under 18 Years of Age)

Name: _____ Employer: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Social Security # (REQUIRED): _____

Home Phone: _____ _____ Cell Phone: _____

Work Phone: _____

PATIENT EMPLOYMENT INFORMATION **EMERGENCY CONTACT**

Employed Retired Unemployed Other Name: _____

Employer's Name: _____ Relationship: _____

Employer's Phone: _____ Phone: _____

Occupation: _____

PATIENT INFORMATION

Print Name: _____ Sex: Male Female

Address: _____ h h h _____ Date of

Birth: _____

City, State, Zip: _____ Social Security # (REQUIRED): _____

Home Phone: _____ Marital Status: Married Single Divorced

Work Phone: _____ Who Referred You: _____

Cell/ Pager Phone: _____ Primary Physician: _____