PATIENT INFORMATION

PLEASE PRINT LEGIBLY

Date ____________________

Legal Name ____________________ Date of Birth ____________________

Previous Name(s) ____________________ Social Security Number ____________________ ❍ Male ❍ Female

Mailing Address ____________________ City ____________________ State ________ Zip ____________

Home Phone ____________________ Cell Phone ____________________ Other Phone ____________________

Email ____________________ Employer ____________________ Employer Phone ____________________

May test results be left in a voicemail on:

Home phone? ❍ Yes ❍ No Cell phone? ❍ Yes ❍ No Other phone? ❍ Yes ❍ No Work phone? ❍ Yes ❍ No

May test results be sent in an email or through a patient web portal? ❍ Yes ❍ No

Spouse's/Partner's Name ____________________ Phone(s) ____________________

May we share your health information with this person? ❍ Yes ❍ No On this person's voicemail? ❍ Yes ❍ No

Emergency Contact's Name ____________________ Phone(s) ____________________

May we share your health information with this person? ❍ Yes ❍ No On this person's voicemail? ❍ Yes ❍ No

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RESPONSIBLE PARTY (Guarantor)

Complete this section as the guarantor only if someone other than the patient is financially responsible.

Name ____________________ Date of Birth ____________ Social Security Number ____________________

Mailing Address ____________________ City ____________________ State ________ Zip ____________

Home Phone ____________________ Cell Phone ____________________ Other Phone ____________________

Relationship to Patient ________________ Employer ________________ Employer Phone ____________________

INSURANCE INFORMATION

Complete this section. Please provide insurance card(s) at time of visit.

Primary Insurance ____________________ Group Number ____________ Policy ID Number ____________

Policyholder Name ____________________ Policyholder Date of Birth ____________________

Relationship to Patient: ❍ Self ❍ Spouse ❍ Child ❍ Other ____________________

Secondary/Supplemental Insurance ________________ Group Number ____________ Policy ID Number ____________

Policyholder Name ____________________ Policyholder Date of Birth ____________________

Relationship to Patient: ❍ Self ❍ Spouse ❍ Child ❍ Other ____________________

WORKERS' COMPENSATION

Is this a work-related injury? ❍ Yes ❍ No Date of Injury ____________________

Is this a work-related injury NOT being filed with Workers' Compensation? ❍ Yes ❍ No

Was the injury reported to employer? ❍ Yes ❍ No Supervisor ____________________

May we share claim-related health information with your employer? ❍ Yes ❍ No

Workers' Compensation Insurance Carrier ____________________