

**GENERAL**

Patient Name				Last Name		First Name		M.I.		Today's Date (MM/DD/YY)	
Social Security #			Driver's License / State Issued			Gender			Date of Birth (MM/DD/YY)		
						Male			Female		
Email Address (Tip! Email will get you access to our OSS Patient Portal)						Name of Spouse / Partner					
Home Address		Number		Street		City		State		Zip Code	
Primary Telephone (1st # to reach you)						Secondary Telephone					
						Cell Home Work					
						Cell Home Work					
Emergency Contact, Your Relationship, & Primary Telephone											

**EMPLOYMENT**

Employer & Job Title											
Is this a work related injury?						Work Comp Insurance Carrier & Claim #					
						Yes No					
If yes, has your employer been notified?						Claim Adjuster & Telephone					
						Yes No					

**PHARMACY (Tip! We can refill your Rx faster if you provide us this information)**

Pharmacy Name, Address & Telephone

**MEDICAL REFERRALS**

Who referred you to our practice?

Doctor	Relative	Friend	Internet	Hospital	Insurance Company	Name
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**LEGAL**

Is there a legal case or lawsuit involved with this injury?				Attorney or Liability Representative Name and Telephone			
				Yes No			
Is an attorney, liability carrier, or auto insurance involved in payment?							
				Yes No			

**PRIMARY INSURANCE**

Insurance Company Name			I.D. / Policy Number			Group Number		
Insured Name			Insured Social Security #			Insured Date of Birth (MM/DD/YY)		
Subscriber of the Health Insurance & Relationship			Subscriber Social Security #			Subscriber Date of Birth (MM/DD/YYYY)		

**SECONDARY INSURANCE**

Insurance Company Name			I.D. / Policy Number			Group Number		
Insured Name			Insured Social Security #			Insured Date of Birth (MM/DD/YY)		
Subscriber of the Health Insurance & Relationship			Subscriber Social Security #			Subscriber Date of Birth (MM/DD/YYYY)		

**AUTHORIZATION**

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize examination and all services deemed medically necessary. I authorize the release of all medical information necessary to process my claim. I agree to assume financial responsibility for ALL services provided.

**X**  
 Signature of Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_