PATIENT INFORMATION - *PLEASE PRINT*

PATIENT NAME: _____ SOCIAL SECURITY #: _____

LOCAL ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: _____ CELL: _____

EMAIL: _____COMMUNICATION PREFERENCE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

HAND DOMINANCE: *LEFT OR RIGHT* RACE: _____ ETHNICITY: _____

NAME OF EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

PERSON RESPONSIBLE FOR BILL: _____

RELATIONSHIP: _____ D/O/B: _____ OWN OR RENT: _____

NORTHERN OR ALTERNATE ADDRESS: _____

PRIMARY DOCTOR: _____ REFERRING DOCTOR: _____

PHARMACY: _____LOCATION: _____
CROSS STREET

CITY_____ PHONE: _____

ARE WE SEEING YOU BECAUSE OF THE FOLLOWING?

AUTO ACCIDENT? _____ DATE: _____ WHERE OCCURRED: _____
WRITE YES OR NO

WORKERS COMPENSATION: _____ DATE: _____ REPORTED TO EMPLOYER: _____
WRITE YES OR NO *WRITE YES OR NO*

NAME OF YOUR ATTORNEY: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ID #_____

SECONDARY INSURANCE_____ID#_____

EMPLOYMENT INFORMATION

PATIENT EMPLOYER: _____ YOUR POSITION:_____

ADDRESS: _____ WORK PHONE: _____

PLEASE READ

PLEASE GIVE OUR RECEPTIONIST YOUR INSURANCE CARDS SO THAT WE MAY PHOTOCOPY THEM. WE HAVE REQUESTED YOUR INSURANCE INFORMATION FOR OUR RECORDS ONLY. PAYMENT IS EXPECTED AT THE TIME OF SERVICE, UNLESS WE PARTICIPATE WITH YOUR INSURANCE, OR YOU HAVE *PREVIOUSLY* SET UP A PAYMENT PLAY WITH OUR OFFICE. **CO-PAYS AND DEDUCTABLES ARE DUE AT TIME OF SERVICE.** DR. CASSIDY AND DR. GUERIN DO PARTICIPATE WITH MEDICARE. PLEASE DO NOT HESITATE TO DISCUSS ANY QUESTIONS REGARDING YOUR INSURANCE OR PAYMENT WITH US.