LIEN / MED-PAY PATIENT INFORMATION

Date ______________ [ ] Established Patient [ ] New Patient

PATIENT INFORMATION:

Name Last:______________________ First:__________________ Date of Birth: _______________ Sex: [ ] Male [ ]Female

Address ____ City: ________________________ Zip: ___________________

Phone: Home ( ) _____-__________ Work: ( ) ______-________________ Cell: ( ) ________-

____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Current Employer: ____ Phone No:( )_______-_______________

Address: ___________________________________City: _______________________________ Zip:________________

Social Security #: _________-_________-_________ Driver License #: ________________________

Name of Person to be contacted in case of emergency: ___________________________________ Phone No:

____

Relationship to patient: ______________________

PERSONAL INJURY INFORMATION:

Name of Insurance Company ____ Phone No: ________________________________

Insurance Address: ____

Name of Insured: ____ Date of Injury: __________________________________

Policy No:__________________________________ Claim:__________________________ Adjustor: name:___________________

Auto Accident: [ ]yes [ ]no **Lien** Case: [ ]yes [ ]no

ATTORNEY INFORMATION:

Name:____ Phone No: __________________________

Address:____ City:________________________ Zip:_____________________

Contact person:_____________________________________

Medical Records: Authorization is here by granted for release of any information required to process this claim. A copy of this authorization **is as valid as the original**

Consent to Treatment: I, the undersigned hereby consent to the administration and performance of all diagnostic procedures and treatments which, in the judgment of my physician/nurse practitioner, maybe considered necessary or advisable. I further agree that if I decide to leave without receiving treatment or without the consent of my physician/nurse practitioner, he/she shall not be liable for the consequences of such decision.

Patient Signature: ____ Date: _____________________________