Patient Information

Name_____ Home Phone#_____ Alt Phone#_____

Address_____ City_____ State_____

Zip_____ Sex (Male or Female) _____ Date of Birth___/___/_____

Social Security #_____-_____-_____ Marital Status (S, M, D, W) _____

Race: _____ Language: _____

Employer/Department_____ Work Phone#_____

Referring Doctor_____ Primary Doctor_____

Emergency Contact_____ Relationship_____ Phone#_____

Do you have health insurance? Yes or No Insurance_____

Who is the primary insurance holder? _____ D.O.B. _____

What pharmacy do you use? _____ Address/Phone_____

Have you received a prescription for any narcotics or pain medications in the past 30 days? Yes or No: If yes, what? _____

No prescriptions will be called in after hours

~Section Below For Medicare Patients Only~

Medicare Waiver

Under Section 1862 (a) (I) of the Medicare law, Medicare will only pay for services that are deemed to be "reasonable and necessary". If Medicare determines that a particular service is not necessary, Medicare reserves the right to deny payment of that service. You will be liable for payment of such services.

By signing the following, I have read, understand, and agree to comply with the terms of this document.

Patient's Signature_____ Date_____

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