PATIENT INFORMATION

Date ___________________

Email ____

Last Name____ Middle Initial _____________ First Name ____

Social Security # ____________________________ Home #_______________________________________ Work/Cell # ______________________________________

Address ____City__________________________________State ___________ Zip ______________

Marital Status___________________________ Birthdate ____________________Age ________ Sex _________Height ___________ Weight ______________

What problems are you being seen for today? (Please indicate right or left side)____

Date of Injury ______________________________ Place of Injury (ex. Home/Work)____

How did injury occur? ____ Date X-rays Taken ___________ Place X-rays Taken __________________________

Is this a second opinion only? ____ Who referred you to us? ____

Primary Care Doctor Name ____ Primary Care Doctor Phone #____

Are you pregnant? __________________ Patient Occupation __________________________________ Employer ____

Alternate or Emergency Contact Name _______________________________ Relation ______________________ Phone # __________________________________

Spouse/Parent (if minor) ____

Pharmacy Name ____ Pharmacy Phone Number ____

INSURANCE INFORMATION

Primary Insurance Name ____ Subscriber Name ____

Subscribers Employer ____ Subscriber S.S. ____

Subscribers Birthdate _____________ Secondary Insurance ________________________________ Subscriber ____________________________________

If both parents have coverage on child, we need: Mom's Birthdate ____________________ Dad's Birthdate __________________________

PLEASE GIVE RECEPTIONIST INSURANCE CARDS TO COPY IF YOU HAVE NOT ALREADY DONE SO **
ALL PATIENTS MUST SIGN THE FOLLOWING ASSIGNMENT OF BENEFITS RELEASE

I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled, including Medicare, commercial insurance and other health plans, to William Kohen, M.D., Brenda Sanford, M.D., Richard S. Bartholomew, D.O., and/or Philip Schmitt, D.O. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as original. I understand that I am financially responsible for all charges whether paid or unpaid by my insurance company or companies. I hereby authorize said assignee/Doctor to release all information necessary to secure payment of services rendered.

SIGNATURE ____ DATE ____________________________________

PRINT NAME ____

FOR MEDICARE PATIENTS ONLY*
MEDICARE ASSIGNMENT

I (patient name) _______________________________________ MEDICARE # _____________________________________ request that payment or authorized Medicare benefits be made on my behalf to doctors William Kohen, M.D., Brenda Sanford, M.D., Richard S. Bartholomew, D.O., and/or Philip Schmitt, D.O. for any service furnished by them. I authorize any holder of medical information about me to be released to the health care financing administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I further understand this is one time authorization and can only be revoked by me in writing.*

SIGNATURE____ DATE __________________________

PAYMENT IS EXPECTED AT TIME OF SERVICE FOR SERVICES NOT COVERED BY INSURANCE

FORM 01.09.19