

Is your condition a result of a work injury?  Yes  No Auto accident?  Yes  No Date of injury \_\_\_\_\_

**PATIENT'S PERSONAL INFORMATION**

Marital Status  Single  Married  Divorced  Widowed Sex:  M  F  
Name - Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_  
Street Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Soc. Sec. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Driver's License No. (State) \_\_\_\_\_  
Employer/Name of School \_\_\_\_\_  Full Time  Part Time  
Spouse's Name - Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_  
Spouse Soc. Sec. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ How do you wish to be addressed? \_\_\_\_\_

**PATIENT/RESPONSIBLE PARTY INFORMATION**

Responsible Party \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Relationship to Patient  Self  Spouse  Other \_\_\_\_\_ Soc. Sec. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Responsible Party's Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Street Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Your Occupation \_\_\_\_\_

**PATIENT'S INSURANCE INFORMATION** (please present insurance card to receptionist)

PRIMARY Insurance Company Name \_\_\_\_\_  
Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Relationship to Insured  Self  Spouse  Child  Other  
Insurance ID Number \_\_\_\_\_ Group Number \_\_\_\_\_  
SECONDARY Insurance Company Name \_\_\_\_\_  
Insurance Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Relationship to Insured  Self  Spouse  Child  Other  
Insurance ID Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Check if appropriate  Medigap Policy  Retiree Coverage

**PATIENT'S REFERRAL INFORMATION**

Referred by \_\_\_\_\_ If referred by a friend, may we thank her or him?  Y  N  
Name(s) of other physicians who care for you \_\_\_\_\_

**EMERGENCY CONTACT**

Name of person not living with you \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**Assignment of Benefits • Financial Agreement**

I hereby give lifetime authorization for payment of insurance benefits to be made to WESTSIDE FAMILY PRACTICE, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable insurance fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Your Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_