Highgrove Medical Clinic, Inc.

PATIENT INFORMATION

Name:____ Soc. Sec.#:____________________ Today's Date___________________

Address:____ City:______________________ State_______ Zip ___________

Home Phone: ( ) ______________________ Work: ( )_____________________ Date of Birth: _______/_______/_______

Marital Status: _____ Single _____ Married _____ Divorced _____Widow/er ______Minor

Employed By:____ Occupation:________________________________

Address:____ City:______________________ State:_______ Zip:___________

Spouse:____ Date of Birth: _______/_______/_______

Spouse's Employer:____ Phone: ( )______________________

Who to notify in an emergency?_____________________________ Relationship_____________ Phone: ( )__________________

Who referred you to this office?:____

MEDICAL INSURANCE INFORMATION

PRIMARY Insurance Co.:____ Policy #:_________________________

Group #:__________________ Address:____ Phone: ( )____________________

SECONDARY Co.:____ Policy #:________________________

Group #:_________________ Address:____ Phone:( )___________________

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE:

Name of Responsible Party:____ Relationship:_______________________

Address:____ City:____________________ State:_______ Zip:______________

Home Phone:( )_________________ Work:( )_________________ Employer:____

IF YOUR INJURY IS JOB RELATED

Date of Injury:_____________________Area Injured:________________________

Name of person who can authorize treatment:____ Job Title:______________________

Company's Work Comp Carrier:____ Phone #: ( )_____________________

Address:____ City:______________________ State:_______ Zip:___________

IF YOUR INJURY IS ACCIDENT RELATED

Accident Date:_____________ Insured Party:________________

Address:____ City:________________________ State:_______ Zip:___________

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, the undersigned, have insurance coverage with ____ and assign directly to
Name of Insurance Company

_____________________ all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand
Name of Doctor

that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date:________________ Signed:____