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Please complete this form completely on front and back.
All information is strictly confidential.

Patient Information

Name _____

Home phone _____ cell phone _____ work phone _____

Address _____ city _____ state ____ zip _____

Email _____

Do you currently reside in or on temporary leave from a nursing facility? _____

If so, please provide the nursing homes address and phone # below:

Birthdate _____ age ____ sex ____ marital status ____ SS# _____

Employer _____ Employer phone _____

If injury, date of accident _____ Work-related? yes no

Place of accident _____

Insurance Subscriber Information

Name _____

Home phone _____ cell phone _____ work phone _____

Address _____ city _____ state ____ zip _____

Birthdate _____ SS # _____ relationship to patient _____

Insurance Information (must have card at registration)

Primary insurance _____ policy # _____

Group # _____ address _____

Other insurance _____ policy # _____

Group # _____ address _____

PLEASE COMPLETE REVERSE SIDE AND SIGN

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Emergency contact (nearest relative friend not living with you)

Name _____ cell phone _____ home phone _____

Address _____ relationship _____

Consent for treatment

I, hereby give my permission for Drs. Einbecker, P. Nicholls, DeGnore, and M. Nicholls to render treatment to me/my dependent. I understand that I will be given all available pertinent information, prior to treatment being rendered. I understand that I may decline recommendation treatments at anytime, but that if I choose to do so, it is at my own medical risk.

Signed _____ date _____

Consent to release/obtain medical information

Permission is, hereby, granted to Drs. Einbecker, P. Nicholls, DeGnore, and M. Nicholls to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment, and/or my referring family physician. Permission is hereby, granted to any facility where I have previously been treated to release medical records/x-rays to Drs. Einbecker, Nicholls, DeGnore, and M. Nicholls.

Signed _____ date _____

Authorization for payment of benefits

I authorize insurance payment benefits to Drs. Einbecker, Nicholls, DeGnore, and M. Nicholls for service rendered. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

Signed _____ date _____

Medicare patients only

I authorize payment of Medicare benefits to Drs. Einbecker, Nicholls, DeGnore, and M. Nicholls for services rendered, and I authorize the release of medical information to Health Care Finance Administration (HCFA) and/or its agents. I have received the supplier standards information sheet.

Signed _____ date _____