PATIENT INFORMATION

PLEASE USE BLACK INK

Last Name First Middle

Street Address Apt #

City State Zip

Home Phone Message Work Phone

Date of Birth ______ Sex: Male/ Female
Month Day Year Circle One

In case of Emergency, Please Notify:

Relationship to patient:_________________ Phone________________

Current Employment Status
Full Time ☐ Part Time ☐ Not Employed ☐ Retired

Current Employer

Street Address Suite #

City State Zip

Occupation

Social Security # Drivers License #

Date of Injury:

Accident Type:

Place of Occurrence:

Please complete the Workers Compensation Insurance Section below if this is a work injury

RESPONSIBLE BILLING PARTY- IF OTHER THAN ABOVE

Last Name First Middle

Street Address Apt #

City State Zip

Home Phone Message Work Phone

Social Security #

Date of Birth:
Month Day Year

Relationship to Patient: Spouse Guardian Attorney Parent (Please circle one)

Employer

Street Address Suite #

City State Zip

WORKERS COMPENSATION INFORMATION

Date of Inury:
Month Day Year

Work Comp Carrier

Street Address Suite #

City State Zip

Attention:

Phone:______________________ Fax:________________

Claim #

Employer at time of injury

PRIVATE INSURANCE INFORMATION

Primary Insurance

Insurance Address

City State Zip

ID# Group #

Insurance Phone: __(_________) ________________________

Secondary Insurance

Insurance Address

City State Zip

ID# Group #

Insurance Phone: __(_________) ________________________

As courtesy, we will bill your primary and secondary insurance companies. If you have tertiary insurance coverage, it will be your responsibility to bill the balance to them.

ASSIGNMENT OF BENEFITS

I hereby assign all benefits to which I am entitled to the provider of these services, Cold Springs Medical Surgical Group, and/or other contractors: I authorize any holder of medical information about me to release any information needed to determine these benefits, and authorize said assignee to release all medical information necessary to secure payment. This assignment will remain in effect until revoked by me in writing; a photocopy is to be considered valid as the original. I understand that I am financially responsible for all charges wether or not paid by said insurance company.

Patient Signature:________________________________ **Date:**______________ **Admitting Initials:** __________

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