Patient Sign-In Sheet

(Please Print)

Today's Date _____

Patient _____ (First) _____ (Middle Init.) _____ (Last Name) Social Security No. _____

Address _____ (Street) _____ (City) _____ (Zip) Telephone (____) _____

Occupation _____ Birth Date _____ Age _____ Sex _____

Driver's License No. _____

Employer-Name _____ Telephone (____) _____

Address _____

Married ☐ Single ☐ Divorced ☐ Widow(er ☐

Spouse/or Responsible Parent _____ (First) _____ (Middle Init.) _____ (Last Name) Social Security No. _____

Address _____ (Street) _____ (City) _____ (Zip) Telephone (____) _____

Occupation _____ Birth Date _____ Age _____ Sex _____

Driver's License No. _____

Employer-Name _____ Telephone (____) _____

Address _____

IN CASE OF EMERGENCY—(Other than husband or wife)—Person not living with you:

Name _____ Relationships _____

Address _____ (Can be out-of-town) (Street) (City) (State) Telephone (____) _____

PLEASE COMPLETE IF PATIENT IS UNDER 21 YEARS OF AGE OR A STUDENT:

Father's Name _____ Mother's Name _____

Father's Occupation _____ Mother's Occupation _____

Father's Employer _____ Mother's Employer _____

Address _____ Address _____

MEDICAL INSURANCE (To be completed in all cases)

Primary Insurance Subscriber _____ Secondary Insurance Subscriber _____

Insurance Co. _____ Insurance Co. _____

Billing Address _____ Billing Address _____

_____ _____

Identification Number _____ Identification Number _____

Group Number _____ Group Number _____

IF INJURY, WHEN AND HOW DID IT HAPPEN?

Home ☐ Work ☐ Automobile ☐ Other _____

Date _____ Hour _____ Last Worked _____

If industrial injury, name and address of employer at time of injury _____

_____

Industrial Insurance Carrier:

Name & Address _____ Claim # _____

REFERRED TO THIS OFFICE BY (Please include address and telephone number of referring doctor)

_____

_____

Is Patient bringing outside x-rays? _____ From? _____

AUTHORIZATION:

The undersigned patient, or authorized individual acting on behalf of the patient understands and agrees as follows:

1. Doctors Jackson, Spencer, Morrison, Kurzweil, Garland, Warden, Bell, Yuan, Tsai and Feldman reserve the right to designate any qualified physician to perform and administer care and treatment of the patient.
2. Doctors Jackson, Spencer, Morrison, Kurzweil, Garland, Warden, Bell, Yuan, Tsai and Feldman are granted permission to release to the insurance carrier, employer, their representatives or referring physician, any information in connection with any treatment rendered to patient, or in patient's behalf at any time such information is requested.
3. Patient shall pay to Doctors Jackson, Spencer, Morrison, Kurzweil, Garland, Warden, Bell, Yuan, Tsai and Feldman such sums as are or may become due for services rendered to the patient, it being understood that in the event patient's insurance company, if there be any, does not make payment, or only a partial payment, this obligation shall be binding personally upon patient.
4. I authorize payment of medical benefits to the doctors rendering services.

_____ Date

_____ Patient, Parent, Guardian