Patient Information: **Facility: OnPoint Performance LLC**

Name: ____ Date: ________________

Address:____

Street City State Zip Code

Phone (Home):______________ (Work): ________________ (Cell): ____________________

Birth Date: _____/______/_____ Sex: (M / F) Email_________________________________

Marital Status: Married Single Divorced Other **Student**: Yes No

Employer (of insured party):

____

Approximate date that symptoms began for problem being seen today: _________________

Insurance Information:

Primary Insurance: _____________________ Secondary Insurance: ______________________

Policy #: _______________________________ Policy #: _____________________________

Group #: ______________________________ Group #: _____________________________

Policy Holder Name: ________________________________ **DOB**: ________________

Patient Relationship to Policy Holder Self Spouse Parent Other

Physician Information:

Name of Referring Physician: _______________________ Phone: _____________________

Address: ______________________________ City: ____________________ State: ______

Emergency Contact:

Name: ____

Phone (Home): _____________________________ (Cell): __________________________

Relationship to Patient:

_______________________________ ________________

Patient/Guardian Signature **Date**