# Osteopathy Chicago, Ltd.

Dr. Dane J. Shepherd, D.O.

## PATIENT INFORMATION

PATIENT NAME: First _____Middle_____ Last _____ Date Of Birth ___/___/_____

PRIMARY CARE PHYSICIAN _____PH.(___)_____ - _____ Date Of Last Physical Exam___/___/_____

RELATIONSHIP STATUS: Single Married Divorced Separated Widowed Domestic Partner

HOME ADDRESS: _____ City_____ State _____ Zip Code _____

HOME PH. (_____) _____-_____ CELL PH. (____) _____-_____ WORK PH. (_____) _____-_____

Best number to reach you at: Home Cell Work May we leave detailed messages at these numbers: Yes or No

EMAIL:_____ Would you like to be added to our email list for upcoming info and newsletters: Yes or No

PATIENT'S EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT NAME _____RELATIONSHIP TO PATIENT_____ PHONE (_____) _____-_____

HOW DID YOU HEAR ABOUT US:_____

## BILLING INFORMATION

RESPONSIBLE PARTY (Guarantor) INFORMATION- For this section, the Guarantor is the person responsible for payment regardless of insurance status.

GUARANTOR NAME_____ DATE OF BIRTH ____/____/____ PH.(____) _____ - _____

ADDRESS_____ Relationship To Patient _____

INSURANCE COMPANY _____ID / Policy #_____Group #_____ Payer ID # _____

**ARE YOU CURRENTLY COVERED BY MEDICARE OR MEDICAID? Yes___ No__ Is Medicare your Primary Insurance? Yes____ No____**

### ASSIGNMENT AND RELEASE OF MEDICAL INFORMATION

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. In consideration of medical treatment to be received, I **do not** hereby assign and transfer over to Osteopathy Chicago, LTD all of my rights, title, and interest in any health insurance policies that are filed on my behalf to the extent benefits are available. I understand that I am financially responsible for all charges. I authorize the release of my medical records, including histories, physicals, doctor's orders, notes, reports and nurse notes to my medical insurer's names above.

### Informed Consent for Treatment

I agree to maintain my own Primary Care Physician with the understanding that Dr. Dane J. Shepherd, D.O. does not provide primary health care services or after hours primary care emergency services. I understand that Dr. Dane J. Shepherd, D.O. does not function as a Primary Care Doctor but rather as an adjunctive physician. I agree that I must maintain my own Primary Care Physician while I am receiving treatment from Dr. Dane J. Shepherd, D. O.

### Accident/Auto Accident or Work Injury

Are you seeking treatment for a condition that is related to or a result of any type of employment, auto accident or other accident?

Yes___ or No___ If Yes, please describe_____

PATIENT/GUARDIAN SIGNATURE _____ DATE ____/_____/_____

PATIENT NAME (PRINTED) _____ DATE ____/_____/_____