PATIENT INFORMATION SHEET

PLEASE PRINT

DATE______________

SINGLE (   )   MARRIED (   )   WIDOW (   )   MALE (   )   FEMALE (   )

PATIENT NAME____

ADDRESS____

CITY______________________________ STATE_________ ZIP CODE______________________

BIRTHDATE______________ AGE NOW______ SOCIAL SECURITY #_______________________

EMPLOYER____

EMPLOYER ADDRESS_______________________CITY_____________STATE_____ZIP________

HOME PHONE__________________________CELL PHONE______________________________

E-MAIL ADDRESS___________________________EMERGENCY PHONE ___________________

FAMILY DOCTOR____

WHO REFERRED YOU TO DR. DAVIS/DR. BEDSOLE?__________________________________

SPOUSE NAME____

SPOUSE EMPLOYER & ADDRESS____

SPOUSE WORK PHONE____

IS THIS WORKERS COMP RELATED?__________IF YES, DATE OF INJURY?______________

PERSON RESPONSIBLE FOR BILL:

GUARANTOR'S NAME__________________________RELATIONSHIP_____________________

GUARANTOR'S EMPLOYER AND ADDRESS____

GUARANTOR'S SOCIAL SECURITY #_______________WORK PHONE____________________

GUARANTOR'S DATE OF BIRTH______________DRIVER'S LICENSE #____________________

PLEASE LIST ANY INSURANCE THAT MAY APPLY TODAY____________________________

DATE OF BIRTH FOR PERSON LISTED ON INSURANCE CARD ________________________

PLEASE BRING ALL INSURANCE CARDS TO THE WINDOW

PLEASE CHECK ONE:

METHOD OF PAYMENT TODAY: CASH (   )   CHECK (   )   VISA/MASTERCARD (   )

PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED