Joint Endeavors

Patient Information: (please print neatly)

Full Name: _____

Mailing Address: _____

City, State: _____ Zip Code: _____

Social Security Number: _____ Birthdate: _____

Phone Number: Home _____ Work _____ Cell _____

E-mail: _____

Marital Status (circle one): Married Single Divorced Widowed Separated

Race (circle one): African-American Asian-American Caucasian Native American Hispanic/Latino Multiracial Other Decline to specify

Place of Employment: _____

Referring Provider: _____ Primary Care Provider: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Approximately when did you last see your primary care provider? _____

Emergency Contact Name, Relationship to You and Phone Number:

_____

Insured Party Information

What is your primary insurance company and ID #? _____

_____

What is your secondary insurance company and ID #? _____

_____

If insured party's information is different from patient information above, please complete the following:

Insured's Full Name: _____ Insured's Birthdate: _____

Insured's Employer: _____

Insured's Age: _____ Insured's Social Security Number: _____

Insured's Contact Numbers: Home _____ Work _____ Cell _____

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize payment of insurance benefits otherwise payable directly to me to the physician.

I authorize Joint Endeavors PLLC to charge my account $50 if I fail to show for a follow-up appointment or cancel it without at least 24 hours notice. I authorize Joint Endeavors PLLC to charge my account $200 if I fail to keep a new patient appointment or cancel it without at least 24 hours notice.

By signing below, I certify that I have read, understand and agree with the office's policies as stated above.

➢ _____ _____

Signature of patient or parent if patient is a minor Date