PATIENT DEMOGRAPHIC INFORMATION (PLEASE PRINT)

Last Name | First Name | Middle Initial

Date of Birth | Gender (Circle) Male Female Other Prefer Not to Answer

Marital Status (Circle) Single Married Divorced Separated Widow Other

Address

City | State | Zip

Home Phone | Cell Phone | ☐Check to authorize text message appointment reminders.

Primary Physician | Referring Physician

Employer | Employer Phone | Occupation:

Emergency Contact Name | Relationship to Patient | Phone Number

INSURANCE INFORMATION

Primary Insurance Carrier Name | Claim Address

Group Number | Subscriber ID

Name of Policy Holder | Policy Holder Employer

Patient's Relationship to Policy Holder | Policy Holder Date of Birth

Secondary Insurance Carrier Name | Claim Address

Group Number | Subscriber ID

Name of Policy Holder | Policy Holder Employer

Patient's Relationship to Policy Holder | Policy Holder Date of Birth

WORK COMPANY OR PERSONAL INJURY (PLEASE COMPLETE, IF APPLIES)

Is this related to a motor vehicle accident? ☐ Yes ☐ No If yes, Date of Injury? ___________________________

Is this a work-related injury? ☐ Yes ☐ No If yes, Date of Injury? ___________________________

Is this person injury related? ☐ Yes ☐ No If yes, Date of Injury? ___________________________
Who is responsible party? _________________

Is an attorney involved? ☐ Yes ☐ No If yes, name of attorney? ______________________

Work Comp Insurance Carrier | Claim #

Address | City | State | Zip

Contact Person & Phone Number

ACKNOWLEDGEMENTS

Acknowledgement of Policy: I understand that I may be charged for missed appointments or failure to cancel at least two hours in advance of an appointment I cannot attend. These charges are not covered by insurance carriers.

I am aware and agree to a 40% surcharge (allowed under Wisconsin Law) added to outstanding balances referred to collections.

Assignment of Benefits: I authorize the release of any medical information to CMS/Medicare when necessary to process my claims. I also request payment of government benefits either to me or the party who accepts assignment. This authorization also permits the release of information to this prober by CMS/Medicare, its intermediaries or carriers on any unassigned CMS/Medicare claims for service rendered by the above provider for any service furnished by this provider. I understand that I am responsible for any charges not covered by my carrier.

Signature: ____Date: __________________________