

# Patient Sign-In Sheet

(Please Print)

Today's Date \_\_\_\_\_

Patient \_\_\_\_\_  
First Middle Init. Last Name Social Security No. \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zip Telephone (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Driver's License No. \_\_\_\_\_

Employer-Name \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Married  Single  Divorced  Widow(er)

Spouse/or Responsible Parent \_\_\_\_\_  
First Middle Init. Last Name Social Security No. \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zip Telephone (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Driver's License No. \_\_\_\_\_

Employer-Name \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

IN CASE OF EMERGENCY—(Other than husband or wife)—Person not living with you:

Name \_\_\_\_\_ Relationships \_\_\_\_\_

Address \_\_\_\_\_  
Can be out-of-town Street City State Telephone (\_\_\_\_) \_\_\_\_\_

PLEASE COMPLETE IF PATIENT IS UNDER 21 YEARS OF AGE OR A STUDENT:

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Mother's Occupation \_\_\_\_\_

Father's Employer \_\_\_\_\_ Mother's Employer \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

MEDICAL INSURANCE (To be completed in all cases)

Primary Insurance Subscriber \_\_\_\_\_ Secondary Insurance Subscriber \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Billing Address \_\_\_\_\_ Billing Address \_\_\_\_\_

Identification Number \_\_\_\_\_ Identification Number \_\_\_\_\_

Group Number \_\_\_\_\_ Group Number \_\_\_\_\_

IF INJURY, WHEN AND HOW DID IT HAPPEN?

Home  Work  Automobile  Other \_\_\_\_\_

Date \_\_\_\_\_ Hour \_\_\_\_\_ Last Worked \_\_\_\_\_

If industrial injury, name and address of employer at time of injury \_\_\_\_\_

Industrial Insurance Carrier:

Name & Address \_\_\_\_\_ Claim # \_\_\_\_\_

REFERRED TO THIS OFFICE BY (Please include address and telephone number of referring doctor)

Is Patient bringing outside x-rays? \_\_\_\_\_ From? \_\_\_\_\_

## AUTHORIZATION:

The undersigned patient, or authorized individual acting on behalf of the patient understands and agrees as follows:

1. Doctors Jackson, Spencer, Morrison, Kurzweil, Garland, Warden, Bell, Yuan, Tsai and Feldman reserve the right to designate any qualified physician to perform and administer care and treatment of the patient.
2. Doctors Jackson, Spencer, Morrison, Kurzweil, Garland, Warden, Bell, Yuan, Tsai and Feldman are granted permission to release to the insurance carrier, employer, their representatives or referring physician, any information in connection with any treatment rendered to patient, or in patient's behalf at any time such information is requested.
3. Patient shall pay to Doctors Jackson, Spencer, Morrison, Kurzweil, Garland, Warden, Bell, Yuan, Tsai and Feldman such sums as are or may become due for services rendered to the patient, it being understood that in the event patient's insurance company, if there be any, does not make payment, or only a partial payment, this obligation shall be binding personally upon patient.
4. I authorize payment of medical benefits to the doctors rendering services.

Date \_\_\_\_\_