

DATE \_\_\_\_\_

(PLEASE PRINT)

PATIENT INFORMATION

Patient: \_\_\_\_\_  
Last Name First Name Middle Name  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Sex: • M • F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Marital Status: • Single • Married • Widowed  
Social Security No: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
In case of emergency notify: \_\_\_\_\_ Phone: \_\_\_\_\_

EMPLOYER INFORMATION

Patient Employed By: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
Business Phone: \_\_\_\_\_  
Spouse (or responsible party) Name: \_\_\_\_\_  
Business Name & Address: \_\_\_\_\_  
Business Phone: \_\_\_\_\_  
Spouse's Social Security No: \_\_\_\_\_ Spouse's Birthday: \_\_\_\_\_

VISIT INFORMATION

Referred By: \_\_\_\_\_ Family Physician: \_\_\_\_\_  
Date of return visit to referring physician: \_\_\_\_\_  
What are your complaints / symptoms? \_\_\_\_\_  
Have you had surgery for this condition? • Yes • No If so, when and what type of surgery? \_\_\_\_\_  
Does your conditions relate to: Work? • Yes • No • Home? • A motor vehicle accident? • Another location?  
Describe briefly how the condition began, where, and the date.

INSURANCE INFORMATION

Please present the following cards: (1) all insurance cards; (2) driver's license; (3) social security

Insurance Name	Name of Insured
Primary _____	_____
Secondary _____	_____

Insurance Authorization and Assignment

I request that payment of authorized Medicare, Medigap, Commercial Carrier, or Workers Compensation benefits on my behalf, be made to EMG Clinics for any services provided to me by EMG Clinic Providers. I authorize EMG Clinics to release to the Health Care Administration and its agents any information needed to determine benefits payable for related services. I understand that I am responsible for any deductible, co-pay, or services not covered by my insurance carrier. I also authorize the physician to release any information required by my insurance company and/or another physician. I give authorization and consent for treatment to EMG Clinics.

\_\_\_\_\_  
Patient Signature or Legal Guardian (if a minor)

\_\_\_\_\_  
Date