PATIENT INFORMATION - PLEASE FILL OUT FORM COMPLETELY!

DATE: _____ ACCOUNT #: _____

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

TELEPHONE: (H) _____ (Cell) _____ (W) _____

E-MAIL ADDRESS: _____

SOCIAL SECURITY# _____ - _____ - _____ SEX: _____ M _____ F

REFERRED BY: _____

EMPLOYER NAME: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

SPOUSE NAME: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

RELATIVE NOT LIVING WITH YOU: _____

PHONE # OF RELATIVE: _____

IS THIS A WORK RELATED INJURY? _____ YES _____ NO

IS THIS A RESULT OF AN AUTO ACCIDENT? _____ YES _____ NO

OTHER: _____ DATE OF ONSET: _____

INSURANCE CO: _____ NAME OF INSURED: _____

GROUP #: _____ POLICY# _____

I understand that it is my responsibility to notify Dr. Goldring's office of any changes in the above information. Fees are payable at the time of examinations, treatments, and x-rays are received, unless other arrangements are made in advance. I understand that I am financially responsible, regardless of insurance payments or non-payment. I am also responsible for any and all collection fee, small claims costs, and/or attorney fees incurred by Dr. Goldring's office in attempting to collect any monies I owe.

_____ _____
SIGNATURE DATE