



Date: _____ Patient Name: _____

Gender: M F Date Of Birth: _____ Age: _____ Social Security #: _____ - _____ - _____

Email Address: _____

Guarantor Information:

Name: _____ Date of Birth: _____

Social Security #: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Work Phone #: _____

Employer: _____ Relationship to Patient: _____

Primary Insurance Company: _____

Member ID #: _____ Group/Policy #: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Employer: _____ Relationship to Patient: _____

Secondary Insurance Company: _____

Member ID #: _____ Group/Policy #: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Employer: _____ Relationship to Patient: _____

Accident? Yes No Auto Accident? _____ Other? _____ Work Related? _____

Claims Adjuster: _____ Phone #: _____

How and where did injury occur? _____

Date of Injury: _____ Affected Body Part(s): _____

If work related, is your claim: Open _____ Closed _____

If claim is closed, are you here for reopening? Yes _____ No _____

Employer at time of Injury: _____

Is an attorney representing you? If yes, please give name: _____

I hereby authorize my insurance benefits to be paid directly to the above physician's office, realizing I am responsible to pay any and all non-covered services. I hereby authorize any physician, chiropractor, surgeon, practitioner, or other person, any hospital including Veterans Administration or governmental hospital, any medical service organization, any insurance company, or other institution or organization to release to each other any and all medical records or information including benefits paid or payable, including information relative to diagnosis, treatment and/or counseling for HIV/aids, psychological conditions, alcohol or controlled substances. A Photostat of this authorization shall be as valid as the original.

I consent to any medical or surgical treatment rendered the patient under the general or special instructions of NOSC physician.

I acknowledge I have received a copy of the Notice of Privacy Practices.

Patient/Guarantor Signature

Date