

APPT. DATE:	APPT. TIME:	AM	PM	DATE SCHEDULED:
PROCEDURE:	MODALITY:	INITIALS:		
SIGNS & SYMPTOMS:	PREVIOUS TREATMENT/SURGERY (type & date):			
PATIENT NAME: (Last name, first name, middle initial)		HOME PHONE ()		
ALIAS	CELL / BEEPER ()			
ADDRESS	RESTRICTIONS WHEN LEAVING MESSAGE/VOICEMAIL: YES: _____			
CITY	SOCIAL SECURITY#			
STATE	ZIP	DATE OF BIRTH	AGE	SEX M F
EMERGENCY CONTACT	PHONE	DATE OF INJURY / ONSET OF SYMPTOMS		
EMPLOYER NAME		WORK PHONE ()		
EMPLOYER ADDRESS		EMPLOYER PHONE: (if different) ()		
CITY	STATE	ZIP	SUPERVISOR NAME	
REQUESTING PHYSICIAN: (Last name, first name, credentials)		PHONE ()		
ADDRESS		FAX NUMBER ()		
CITY	STATE	ZIP	"CC" FILMS/REPORT TO	

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the Center listed above. In the event payments are made directly to me, I agree to remit such payments to the Center. Should my Insurance Company or Attorney refuse to honor the bill, I agree to be responsible for the balance. I further agree to be responsible for said debt and any collection fees or Attorney fees involved in the collection of this debt.

Patient Signature: _____ **Date:** _____

RELEASE OF INFORMATION: This authorization or photo copy hereof, will authorize the release of the requested medical records/reports and or any other records when necessary to Government Agencies, Insurance Carriers, and Review Agencies responsible for pre-certification and payment for services rendered. I further authorize release of such medical records associated for the performance of services requested by me or on my behalf.

Patient Signature: _____ **Date:** _____

RESTRICTION OF RELEASE OF INFORMATON: I am interested in making a formal restriction on the use and disclosure of my protected health information (PHI) and have requested the standard forms to complete. (Use HIPPA restriction form)

Patient Signature: _____ **Date:** _____