COMPREHENSIVE HEALTHCARE

PLEASE PRINT

GENERAL INFORMATION:

PATIENT LAST NAME _____ FIRST NAME _____

ADDRESS _____ CARE OF _____
(Parent or financially responsible person)

CITY _____ STATE _____ ZIP _____ PHONE (WORK) _____

DRIVER'S LIC. # _____ NO. CHILDREN _____ PHONE (HOME) _____

OUT OF STATE ADDRESS _____ PHONE _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____ NATIVE LANGUAGE _____

SEX ☐ M ☐ F	☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER - -

PATIENT'S EMPLOYER'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ OCCUPATION _____

EMPLOYED

☐ FULL TIME ☐ PART TIME
☐ RETIRED ☐ NOT EMPLOYED

STUDENT

☐ FULL TIME ☐ PART TIME
☐ NON STUDENT

CHIEF COMPLAINT _____

NAME & PHONE# OF PRIMARY CARE PHYSICIAN _____

PRIMARY INSURANCE COMPANY NAME	***COMPLETE ONLY IF PATIENT IS NOT THE INSURED***
_____ TYPE ☐ GROUP ☐ PRIVATE MEMBERSHIP/CERT. # _____ POLICY/GROUP# _____	INSURED'S INFORMATION INSURED'S NAME _____ ☐ M ☐ F ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED PATIENT'S RELATIONSHIP TO INSURED _____ INSURED'S DATE OF BIRTH ____/____/____ INSURED'S EMPLOYER _____
SECONDARY INSURANCE COMPANY NAME _____ TYPE ☐ GROUP ☐ PRIVATE MEMBERSHIP/CERT. # _____ POLICY/GROUP# _____	INSURED'S NAME _____ ☐ M ☐ F ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED PATIENT'S RELATIONSHIP TO INSURED _____ INSURED'S DATE OF BIRTH ____/____/____ INSURED'S EMPLOYER _____

AUTOMOBILE ACCIDENT / WORKERS COMPENSATION ONLY

INSURANCE CO. _____ CLAIM # _____ POLICY # _____

ADDRESS _____ PHONE # _____

CITY _____ STATE _____ ZIP _____ ADJUSTER'S NAME _____

ATTORNEY'S NAME _____ CONTACT NAME _____ PHONE _____

ADDRESS _____

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient's Signature _____ **Date** _____

E-Mail Address _____