**First Choice Occupational / Walk-in Clinic**
Patient Demographic and History

Date:_____ Time:_____ Referring Physician:_____

Name:_____ _____
***Last*** ***First*** ***M.I.*** ***Birth Date***

Address:_____
*Street* *City* *State* *Zip Code*

Home Phone #_____ Work Phone # _____

Cell Phone # _____ Email Address: _____

**Circle One:** Married Single Widowed Divorced **Circle One:** Male Female

Medical Insurance: _____ Group & ID#:_____

Effective Date: _____ Insured's SS# _____ Patient's SS#_____

Insured's Name: _____ Insured's DOB: _____

Employer: _____ Occupation: _____

Employers Address: _____

Describe your pain and indicate how long you have had these symptoms:

_____
_____
_____
_____
_

Injury date *if applicable*:_____

**For Office Use Only**

CLM#/PT#_____

CPT _____

ICD-9 _____

I hereby authorize FC to furnish my health insurance company or my employer, or to other third party payers or their designed agents, all the information the above named entities may request concerning treatment for myself and my dependents, including medical records.
I hereby assign to FC the medical and/or radiological benefits to which my dependents or I are entitled under my health insurance plan/plans. I guarantee payment in full for all amounts that are not covered by the assigned third party payer(s). I agree to supply FC proof of my insurance coverage(s) at the time services are rendered. I understand that if I am insured under a managed care plan which is contracted with FC, I will be responsible for payment of all co-payments, deductibles and all non-covered services.

Signed: _____ Date: _____