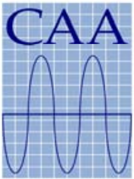

Patient information Form: *Please print*

Date________________

Name____ Marital Status__________________

Address____Sex__________

City____________________________________State_______Zip________________________

Home #________________________Age_______Date of Birth__________________________

Work #____________________________Employer___________________________________

Cell phone #______________________ Occupation___________________________________

E-mail____

Emergency Contact ____

Phone #__________________________ Relationship_________________________________

Have any family members been seen here?____

His/Her Name_____________________________ Phone_____________________________

Chief Complaint____

How did you hear about us?____

Primary care doctor____________________ Phone #__________________City____________

Would you like a report sent to your physician? Yes_______ No_______

ASSIGNMENT OF BENEFITS-RELEASE OF INFORMATION

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plans to CAA. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information that is necessary to secure payment.

Signature____