**In order to help us quickly process this form, we ask your assistance in providing us with complete printed information.**
**If you have insurance, please show us your card so we may copy it.**

**PARENT / GUARDIAN (IF PATIENT IS UNDER 18)**

FIRST NAME________________________ LAST NAME________________________ MI________

SOCIAL SECURITY NUMBER________________________ DATE OF BIRTH ____ /____ /_____ HOME PHONE________________

MAILING ADDRESS ________________________ CITY / STATE / ZIP ________________________

**PATIENT**

FIRST NAME________________________ LAST NAME________________________ MI______ MALE FEMALE

SOCIAL SECURITY NUMBER________________________ DATE OF BIRTH ____ /____ /_____ HOME PHONE________________

MAILING ADDRESS ________________________ CITY / STATE / ZIP________________________

STREET ADDRESS________________________ CITY / STATE / ZIP________________________

RESIDENCE IS A SKILLED NURSING FACILITY, FACILITY NAME:________________________

**EMPLOYMENT STATUS:** ☐ EMPLOYED ☐ SELF-EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ DISABLED ☐ HOMEMAKER ☐ STUDENT ☐ MINOR

EMPLOYER________________________ EMPLOYER PHONE________________________

EMPLOYERS ADDRESS________________________ CITY/STATE/ZIP ________________________

**PLEASE COMPLETE THOSE ITEMS BELOW THAT APPLY TO YOU:**

**INSURANCE** (PRIMARY)
NAME OF INSURANCE________________________
GROUP #______________POLICY #________________
POLICYHOLDERS RELATIONSHIP TO PATIENT:
☐SELF ☐PARENT ☐SPOUSE ☐OTHER

**POLICYHOLDER INFORMATION** (IF OTHER THAN PATIENT)
NAME________________________
SOCIAL SECURITY NUMBER________________________
DATE OF BIRTH________________________
EMPLOYER ________________________
PHONE ________________________

**INSURANCE** (SECONDARY)
NAME OF INSURANCE________________________
GROUP #______________POLICY #________________
POLICYHOLDERS RELATIONSHIP TO PATIENT:
☐SELF ☐PARENT ☐SPOUSE ☐OTHER

**POLICYHOLDER INFORMATION** (IF OTHER THAN PATIENT)
NAME________________________
SOCIAL SECURITY NUMBER________________________
DATE OF BIRTH ________________________
EMPLOYER ________________________
PHONE ________________________

**IS EXAM RELATED TO WORKERS COMPENSATION?** YES NO
**WORKERS COMPENSATION**________________________
CLAIM NUMBER________________________
CLAIM ADDRESS________________________
CITY/STATE/ZIP________________________

**IF YES**,INFORM US FOR ADDITIONAL INFORMATION
HAS INJURY BEEN REPORTED TO THE EMPLOYER? YES NO
DATE OF INJURY ________________________
NATURE OF INJURY________________________
CONTACT PERSON ________________________
CONTACT PHONE ________________________

**PATIENT SIGNATURE**________________________________________ **DATE**___________ AIC-33 02/04/05