Dr / Mr / Mrs / Ms / Miss

Name:_____ Gender:____ Date of Birth_____

To protect your privacy what name would you like us to use when we call you from the waiting room?

_____ Marital Status: M W S D SEP

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: (____)_____ Cell Phone #:(____)_____

E-mail Address: _____

Employer:_____ Phone: (____)_____

Primary Care Physician:_____ MD Phone:(_____)_____

PCP Address:_____

Is this a work related injury? _____Yes_____NO **Is this Cosmetic?** ____yes ____NO

Primary Coverage (Worker's Compensation/Auto Accident information on back side)

Insurance Company Name:_____

Member ID#:_____ Group #:_____ Co-Pay:_____

Effective Date of Ins:_____ Relation to insured: _____self ____spouse ___child

Secondary Coverage

Insurance Company Name:_____

Member ID#:_____ Group #:_____ Co-Pay:_____

Effective Date of Ins:_____ Relation to insured: _____self ____spouse ___child

Insurance Subscriber Information Same as above ☐

Insurance Policy Holder's Name: _____

Sex:_____ Date of Birth:_____

Address:_____ Home Phone:_____

City:_____ State:_____ Zip Code: _____

Employer:_____ Phone:(_____)_____

Worker's Compensation ☐ or Auto Insurance ☐

Insurance Carrier Name:_____

Address:_____ Phone #:_____

City:_____ State:_____ Zip Code:_____ Fax #:_____

Claim #:_____ Date of accident:_____Adjuster:_____

UR Company: _____ Phone #:_____
Fax#: _____

How did you hear about us? (Please be specific)

Primary Care MD_____ Friend/Relative_____ Radio_____

Specialty Care MD_____ Internet/Website_____ Other_____

Newspaper _____ Salon _____ Yellow pages____

Authorization for Release of Information

I authorize Health professionals, using their best judgment, to disclose to a **family member, relative, or any other person I identify** (see below), health information relevant to that person's involvement in my care or payment related to my care. **The person listed below will also be considered your emergency contact person.**

Name:_____ Relationship: _____ Phone: (H)_____

(W)_____

Name:_____ Relationship: _____ Phone: (H)_____

(W)_____

Extended Authorization

I hereby authorize ***my physician*** to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to my physician all payments for medial services rendered to myself or my dependents. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain a referral, obtain proper approvals or to give correct insurance information.

Signature:_____ Date:_____

Consent for Treatment

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment, as may be deemed necessary by ***Dr. Shenko*** and/or its designees.

Signature:_____ Date:_____