PATIENT INFORMATION

Patient Name:____ M / F________

Home PH#: (_____) ______-_______ Cell PH#: (_____) ______-_______* D.O.B.______________

Address:____Marital Status: __________

City:____ State: _______ Zip: _____________

SS#: _________________Age: ______ Email Address:____

Employer/School:____

Occupation:____ PH: (_____) _____-_______

Please check below (required by federal government

Race:	American Indian/Alaskan Native	Asian	Black	Caucasian	Other	Pacific Islander	Declined

Ethnicity:	Hispanic:	Non-Hispanic	Declined

***I give HSWC permission to call or text message me about my appointment or other matters on my cell phone.**

EMERGENCY INFORMATION

Contact:____ **Relationship:** ____________

Phone #'s: (_____) ______-_______ **Cell PH#: (_____) ______-_______**

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PRIMARY INSURANCE

Ins. Company:____

Member ID#: ____________________________ Group #: ______________

If different from the patient…

Insured Name:____ D.O.B: _________________

Employer:____ PH#: (____) _____-______

SECONDARY INSURANCE

Ins. Company:____

Member ID#: _____________________________ Group #: _____________

If different from the patient…

Insured Name:____D.O.B: _________________

Employer:____PH#: (____) _____-______

I, the undersigned, certify that I (or my dependent) have coverage with _______________________ and assign directly to Karen Pryor, PhD, PT, all insurance benefits, if any, and otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the above party to release information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ____

Signature of Patient/ Parent/ Guardian Date