PATIENT'S NAME: _____ Age _____ Birthdate _____ Sex F or M
Last First Middle

Please circle one: Married Single Divorced Separated Widow Widower

Address _____ _____ _____
Number & Street Name Apt # City, State & Zip Code

Home Phone _____ Cell Phone _____
Area Code & Number Area Code & Number

Social Security _____ Drivers License _____

Employer Name _____ Address _____
City, State & Zip Code

Occupation _____ Business Phone _____ Ext ____
Area Code & Number

Spouse's Name _____ Their Business Phone _____ Ext ____
Area Code & Number

Name of Nearest Relative (not living with you) _____ Phone _____

**IF PATIENT IS A DEPENDENT ON PARENT'S INSURANCE, PLEASE COMPLETE:**

Father's Name _____ Mother's Name _____

Father's Address _____ Mother's Address _____
Number, Street Name, City, State & Zip Code Number, Street Name, City, State & Zip Code

Father's Employer _____ Mother's Employer _____

Business Phone _____ Ext ___ Business Phone _____ Ext_____
Area Code & Number Area Code & Number

Name of Responsible Party _____

Was this an accident YES___ NO ___ On the Job Injury? YES ___ NO ___ Date of Accident _____

Referring Doctor's Name _____

Have you had any surgery within the last 90 days? YES ____ NO ___ YES? Date _____

How do you plan to pay for today's visit? Cash ___ Check ___ Credit Card __ Type: MC VS AM DISC

**Primary Insurance**

Insurance Name _____
Address _____
Insured Name _____
Insured: _____ Self ____ Spouse ____ Parent
Insured Social Security # _____
Group # _____
Insured Date of Birth _____
Employer of Group Ins. _____
Medicare # _____ Medicaid # _____

**Secondary Insurance**

Insurance Name _____
Address _____
Insured Name _____
Insured: _____ Self ____ Spouse ____ Parent
Insured Social Security # _____
Group # _____
Insured Date of Birth _____
Employer of Group Ins. _____
Medicare # _____ Medicaid # _____

1. I attest the above information is true and accurate. I understand that falsifying medical records is a felony punishable by law.
2. I assign all medical benefits to which I am entitled to: Dr Cary Tanamachi or Dr. Terry Sobey (circle the Doctor you are seeing). A photocopy of this assignment is to be considered as the original.

PATIENT NAME (PRINT) _____ DATE _____

SIGNED BY _____