



Patient Information

415 North Center Street • Suite 102 • Hickory, NC 28601

Account # _____

Today's Date: _____ Surgeon you are here to see: _____

Patient Name: _____ Social Security # ____/____/____
Last First MI

Physical Address: _____

Mailing Address: _____

Home Phone: () _____ - _____ Cell Phone: () _____ - _____

Email address: _____

Date of Birth: ____/____/____ Age: _____ Male Female

Employer: _____ Employer Phone: () _____ - _____

Marital Status: Single Divorced Widowed Married: Spouse's Name: _____

Spouse's Employer: _____ Employer Phone: () _____ - _____

Primary Doctor: _____ Doctor who asked us to see you (if different): _____

Emergency contact person (someone not living with you): _____

Relationship to you: _____ Home: () _____ - _____ Work: () _____ - _____

If the patient is under age 18 or mentally or physically handicapped, please complete the following:

Name of parent, legal guardian or power of attorney: _____

SSN ____/____/____ Employer: _____ Work: () _____ - _____

Is their address the same as above? Yes No: If no, what is the other address?

Insurance Information

Does the patient have medical insurance? No (*see reverse side for financial policy*) Yes (*please complete the following*)

Primary Insurance

Subscriber name: _____

Policy holder name (if different): _____

Policy holder DOB: _____

Secondary Insurance

Subscriber name: _____

Policy holder name (if different): _____

Policy holder DOB: _____

Please Note:
We must have a copy of your insurance card to file a claim

Workmen's Compensation (*if injury occurred at work*)

Policy Carrier: _____

Employer: _____

Employer's Street Address, City, State & Zip: _____

Employer Business Phone: () _____ - _____

Date of injury: _____ Date verified: _____ With whom: _____

Claims to be sent to: _____

