

Welcome To Our Office

The Care Group, P.C.

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PLEASE PRINT and COMPLETE ALL PARTS

Patient Number _____

Today's Date _____

PATIENT INFO: (This section refers to PATIENT ONLY)

Name _____ Referred By _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Addr _____

Date of Birth _____ Age _____ Sex _____ Social Security # _____

Work Phone _____ Occupation _____ Employer _____

Spouse _____ Employer _____ Work Phone _____

Relationship to Responsible Party: Self Spouse Son Daughter Other

RESPONSIBLE PARTY: (Person who should receive the bill)

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Auto Injury Work Comp Claim # _____ Date of Accident _____

Other Injury (specify) _____ Date of Accident _____

This space for office use only.

NOTIFY IN EMERGENCY: (NOT LIVING WITH YOU)

Name _____ Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

PLEASE SIGN
BY BOTH X'S

I authorize payment of medical benefits to physician or
supplier for these services and all future claims.

X _____

Signed (Insured or Authorized Person)

I authorize the release of any medical information
necessary to process this claim and all future claims.

X _____

Signed (Insured or Authorized Person)