

**ENTRANCE APPLICATION**

*WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION.  
SO WE MAY FILE YOUR INSURANCE FORMS FOR YOU, WOULD YOU PLEASE FILL OUT THE PERSONAL INFORMATION BELOW?  
IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK PERSON. THANK YOU!*

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Gender  Male  Female Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Marital Status S M W D

Job Title \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Birthdate \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Person responsible for this account \_\_\_\_\_

Name of person on your health insurance card \_\_\_\_\_

Name of their employer \_\_\_\_\_ City \_\_\_\_\_

Employer Phone \_\_\_\_\_

Children—Names & Ages \_\_\_\_\_

In case of emergency, whom should we contact? \_\_\_\_\_

Phone \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

What is your primary complaint? \_\_\_\_\_

IS THIS WORKMAN'S COMPENSATION? \_\_\_\_\_ IS THIS PERSONAL INJURY? \_\_\_\_\_

**Patient Informed Consent**

I, \_\_\_\_\_, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature \_\_\_\_\_

(Office use only)

Account Number

Date