

Dr / Mr / Mrs / Ms / Miss

Name: _____ Sex: _____ Date of Birth _____

To protect your privacy what name would you like us to use when we call you from the waiting room?

_____ Marital Status: M W S D SEP

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Cell Phone #: (_____) _____

Social Security #: _____ E-mail Address: (for special offers): _____

Employer: _____ Phone: (_____) _____

Primary Care Physician: _____ MD Phone: (_____) _____

PCP Address: _____

Is this a work related injury? _____ Yes _____ NO If **Yes** please complete back of form

Health Insurance Coverage

Insurance Company Name: _____

Member ID#: _____ Group #: _____ Co-Pay: _____

Effective Date of Ins: _____ Relation to insured: _____self _____spouse _____child

Secondary Coverage if applicable (Exp: Medicare and Medex)

Insurance Company Name: _____

Member ID#: _____ Group #: _____ Co-Pay: _____

Effective Date of Ins: _____ Relation to insured: _____self _____spouse _____child

Insurance Subscriber Information

Same as above

Insurance Policy Holder's Name: _____

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

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Phone: (_____) _____

Worker's Compensation or Auto Insurance

Insurance Carrier Name: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____ Fax #: _____

Claim #: _____ Date of accident: _____ Adjuster: _____

UR Company: _____ Phone #: _____

How did you hear about us? (PLEASE BE SPICIFIC)

Primary Care MD _____ Friend/Relative _____ Radio _____

Specialty Care MD _____ Internet/Website _____ Other _____

Newspaper _____ Salon _____ Yellow pages _____

Authorization for Release of Information

I authorize Health professionals, using their best judgment, to disclose to a **family member, relative, or any other person I identify** (see below), health information relevant to that person's involvement in my care or payment related to my care. **The person listed below will also be considered your emergency contact person.**

Name: _____ Relationship: _____ Phone: (H) _____

(W) _____

Name: _____ Relationship: _____ Phone: (H) _____

(W) _____

Extended Authorization for: Dr. Ekstrom

I hereby authorize **my physician** to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to my physician all payments for medial services rendered to myself, or my dependents. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain a referral or to give correct insurance information.

Signature: _____ Date: _____

Consent for Treatment

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment, as may be deemed necessary by **Dr. Ekstrom** and/or its designees.

Signature: _____ Date: _____