WELCOME TO OUR OFFICE

PLEASE COMPLETE ALL SECTIONS OF THIS INFORMATION FORM

NAME______________________________ HOME PHONE__________________ WORK PHONE__________________

ARE YOU A RESIDENT OF A NURSING FACILITY? Y___ N ___

LOCAL ADDRESS ______________________________ CITY/STATE __________________ ZIP ____________

NORTHERN ADDRESS ______________________________ CITY/STATE __________________ ZIP ____________

DATE OF BIRTH ____________ S.S.# ________________ REFERRING PHYSICIAN ______________________________

Do we have permission to leave appointment information on your home answering machine/voice mail/cell phone: Y___ N___

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN ABOVE

NAME______________________________ HOME PHONE__________________ WORK PHONE__________________

ADDRESS____

INSURANCE INFORMATION

IS THE INSURANCE THRU YOUR EMPLOYER OR YOUR SPOUSE'S EMPLOYER? SELF ______ SPOUSE ______

IF SPOUSE: NAME: ____

DATE OF BIRTH ____________ SOCIAL SECURITY #______________________

EMPLOYER: ____

IF SELF: EMPLOYER: ____

IS THIS CLAIM RELATED TO A WORKER'S COMP OR AUTO ACCIDENT?

IF YES, DATE OF INJURY?

IS THERE A POSSIBILITY YOU MAY BE PREGNANT? Y___ N ___

HOW DO YOU WISH TO PAY TODAY? CREDIT CARD ___ CHECK ___ CASH ___

I understand and agree, regardless of my insurance status, all deductible and co-payment charges are due at time of service. I further understand that my insurance may not pay for all my health care costs, insurance only pays for covered items and services when their guidelines are met, and insurance may not pay for a particular item or service even though my doctor recommends that I have this done. I am financially responsible for my bill, and any non-covered charges. I have read all the information on this form and have completed the above information as true and correct. If necessary, I authorize RAVE to request office notes from my ordering physician and the release of any medical information needed for my medical care or other information as needed to process this claim.

SIGNATURE ____ DATE ________