

Highgrove Medical Clinic, Inc.

PATIENT INFORMATION

Name: _____ Soc. Sec.#: _____ Today's Date _____

Address: _____ City: _____ State _____ Zip _____

Home Phone: () _____ Work: () _____ Date of Birth: ____/____/____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widow/er ____ Minor

Employed By: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse: _____ Date of Birth: ____/____/____

Spouse's Employer: _____ Phone: () _____

Who to notify in an emergency? _____ Relationship _____ Phone: () _____

Who referred you to this office?: _____

MEDICAL INSURANCE INFORMATION

PRIMARY Insurance Co.: _____ Policy #: _____

Group #: _____ Address: _____ Phone: () _____

SECONDARY Co.: _____ Policy #: _____

Group #: _____ Address: _____ Phone: () _____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE:

Name of Responsible Party: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Work: () _____ Employer: _____

IF YOUR INJURY IS JOB RELATED Date of Injury: _____ Area Injured: _____

Name of person who can authorize treatment: _____ Job Title: _____

Company's Work Comp Carrier: _____ Phone #: () _____

Address: _____ City: _____ State: _____ Zip: _____

IF YOUR INJURY IS ACCIDENT RELATED Accident Date: _____ Insured Party: _____

Address: _____ City: _____ State: _____ Zip: _____

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, the undersigned, have insurance coverage with _____ and assign directly to
Name of Insurance Company

_____ all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand
Name of Doctor

that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: _____ Signed: _____