First State Physicians

Physical Medicine & Rehabilitation Center

**Kevin J. McDermott, D.C.**

# _____

## Patient Intake Form

Full Name: _____ Date: _____
First MI Last

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

Age: _____ Birth Date: _____ Social Security Number: _____

Employer Address: _____ Occupation:_____

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I am (circle) Single/Married/Divorced/Widowed/Separated

Emergency Contact: _____Emergency Contact Phone Number: _____

## Insurance Information

Do you have health insurance? _____ Yes _____ No

| Primary Insurance | Secondary Insurance |
|---|---|
| Insurance Company: | Insurance Company: |
| Policy Holder's Name: | Policy Holder's Name: |
| Relationship to Patient: | Relationship to Patient: |
| Policy Holder's Birth Date: | Policy Holder's Birth Date: |
| Group Number: | Group Number: |
| Policy ID Number: | Policy ID Number: |

**Please have your insurance card and driver's license ready so they can be copied for the clinic's records.**

## Consent for Treatment

***Assignment & Release*** *- By signing below, I authorize [clinic name] to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to First State Physicians and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

*By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient*

Signed _____ Date _____

Date of Accident: _____