DWITE D. DAHMS, M.D. GARY A. PATTEE, M.D.
PIERRE DURAND, M.D. MICHAEL T. VERCILLO, M.D.
JOHN DELGADO, M.D.

PATIENT REGISTRATION INFORMATION

PLEASE PRINT AND COMPLETE ALL SECTIONS!

IS YOUR CONDITION A RESULT OF A WORK INJURY? YES NO **AN AUTO ACCIDENT?** YES NO

PATIENT'S PERSONAL INFORMATION

Name_____ Date of Birth ____/____/____ Age ____ Sex: M F

Address_____City_____State_____Zip_____

Home Phone ( )_____Work Phone ( )_____Cell Phone( )_____

Marital Status: S M D W P (separated)

Email address _____

Occupation_____

Employer/School Name_____Driver's License:_____

Address_____ City_____State_____ Zip_____

Social Security # ____-____-____ Date of Retirement _____

Spouse's Name _____ Spouse's Work Phone ( ) _____

Spouse's Social Security # ____-____-____

EMERGENCY CONTACT

Name of person not living with you _____

Relationship _____

Address_____City_____State_____Zip_____

Home Phone ( )_____Work Phone( )_____Cell Phone( )_____

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PATIENT'S REFERRAL INFORMATION

Referred by_____ Your Primary Physician _____

RESPONSIBLE PARTY INFORMATION (if not same as patient)

Name _____ Date of Birth _____/____ /_____
Month Day Year

Relationship to Patient: Self____ Spouse____ Other_____

Address _____ City _____State_____Zip_____

Home Phone ( )_____Work Phone( )_____Cell Phone ( )_____

Employer's Name _____ Phone Number ( )_____

Address _____ City _____ State_____ Zip_____

PATIENT'S INSURANCE INFORMATION

PRIMARY insurance company's name_____

Insurance ID#_____ Group Name_____ Group# _____

SECONDARY insurance company's name_____

Insurance ID#_____ Group Name _____ Group# _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____,have received the Notice of Privacy Practices from Dahms, Durand, Pattee, Vercillo, and Delgado M.D.

Sign_____ Date: _____

SUMMARY OF OUR FINANCIAL POLICY

I, _____,have received the Summary of Financial Policy from Dahms, Durand, Patee Vercillo, and Delgado M.D.

Sign _____ Date: _____