~ PATIENT INFORMATION ~

First Name _____ Last Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip Code _____

Sex: ☐ Female ☐ Male Birthdate: ___ / ___ / ___ Age: _____

Martial Status:
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Social Security # _____

Name of Employer _____ Occupation _____

Emergency Contact Name _____ Relationship _____ (_____) _____ Emergency Contact Phone

Whom may we thank for your referral? _____

Email Address _____ (please print clearly)

(_____) _____ Home Phone

(_____) _____ Cell Phone

(_____) _____ Work Phone

(_____) _____ Fax Number

~ RACE / ETHNICITY / LANGUAGE~

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian
☐ White

☐ Not Hispanic or Latino
☐ Hispanic/Latino

What is your preferred language? _____

~ PRIVACY INFORMATION ~

What phone number would you like us to contact you at?	HOME	WORK	CELL
May we leave a message stating your appointment date and time?	YES	NO	
If we are unable to contact you, do we have permission to speak with someone else regarding your appointments, test results, medication, treatment, etc.?	YES	NO	

If yes, with whom: _____ Name _____ Relationship (_____) _____ Phone Number

~ INSURANCE ~

Primary Insurance _____

Policy Holder Name (other than patient) _____ Policyholder Birthdate _____

Secondary Insurance _____

Policy Holder Name (other than patient) _____ Policyholder Birthdate _____

Please complete other side →

~ ADDITIONAL INFORMATION ~

1. Did you sustain an injury at work?	YES	NO
2. Are your injuries a result of an accident?	YES	NO
3. Are you or your spouse currently employed?	YES	NO
4. Have you served in the military?	YES	NO
5. Do you have any secondary policies?	YES	NO
6. Have you made any changes to your coverage in the last 12 months?	YES	NO

~ PHARMACY ~

Do you use a local pharmacy or mail order service?

☐ LOCAL PHARMACY ☐ MAIL ORDER

_____
Pharmacy Name

(_____) _____
Pharmacy Phone Number

_____ , _____
Local Pharmacy Location - Road and City

~ ASSIGNMENT AND RELEASE ~

I certify that I have coverage with _____ and assign directly to Charles Godoshian, M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all Insurance submission.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will stay in effect until my written withdrawal. Should any of the above information change, I will notify the office immediately.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Please Print name if not Patients Signature **Relation to Patient**