Dr / Mr / Mrs / Ms / Miss

Name:______________________________________ Sex:_______ Date of Birth_____________

To protect your privacy what name would you like us to use when we call you from the waiting room?

____ Marital Status: M W S D SEP

Mailing Address:____

City:______________________________________ State:__________ Zip Code:_____________

Home Phone: (_____)__________________________ Cell Phone #:(____)____________________

Social Security #:__________________E-mail Address: (for special offers):______________________

Employer:_______________________________________ Phone: (______)_________________

Primary Care Physician:____________________________ MD Phone:(______)_____________

PCP Address:____

Is this a work related injury? _____Yes_____NO **Is this Cosmetic?** ____yes ____NO

Primary Coverage (Worker's Compensation/Auto Accident information on back side)

Insurance Company Name:____

Member ID#:_______________________________ Group #:________ Co-Pay:__________

Effective Date of Ins:_______________ Relation to insured: _____self ____spouse ___child

Secondary Coverage

Insurance Company Name:____

Member ID#:_______________________________ Group #:________ Co-Pay:__________

Effective Date of Ins:_______________ Relation to insured: _____self ____spouse ___child

Insurance Subscriber Information

Same as above ☐

Insurance Policy Holder's Name: ____

Sex:_______ Date of Birth:_______________Social Security #:_____________________________

Address:____ Home Phone:____________________

City:__________________________________ State:__________ Zip Code: _________________

Employer:___________________________________ Phone:(______)_____________________

Worker's Compensation ☐ or Auto Insurance ☐

Insurance Carrier Name:____

Address:______________________________ Phone #:________________________

City:____________________ State:_____ Zip Code:_______ Fax #:__________________

Claim #:_________________ Date of accident:_______Adjuster:______________________

UR Company: __________________________ Phone #:________________________

How did you hear about us? (Please be specific)

Primary Care MD____________________ Friend/Relative____________________ Radio__________

Specialty Care MD__________________ Internet/Website___________________ Other__________

Newspaper _________________________ Salon ____________________________ Yellow pages____

Authorization for Release of Information

I authorize Health professionals, using their best judgment, to disclose to a **family member, relative, or any other person I identify** (see below), health information relevant to that person's involvement in my care or payment related to my care. **The person listed below will also be considered your emergency contact person.**

Name:_______________________________ Relationship: ___________ Phone: (H)_________________

(W)_________________

Name:_______________________________ Relationship: ___________ Phone: (H)_________________

(W)_________________

Extended Authorization

I hereby authorize ***my physician*** to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to my physician all payments for medial services rendered to myself or my dependents. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain a referral, obtain proper approvals or to give correct insurance information.

Signature:__________________________________ Date:___________________

Consent for Treatment

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment, as may be deemed necessary by ***Dr. Shenko*** and/or its designees.

Signature:__________________________________ Date:___________________