



Date: \_\_\_\_\_ Nickname: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_ Sex:  M  F

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_

Referred by: \_\_\_\_\_ Date of Accident: \_\_\_\_\_ Accident Reported to Auto Insurance?  Y  N

Would you like an email reminder? Y N Email Address: \_\_\_\_\_

**\*\*AUTO INSURANCE INFORMATION\*\***

Patients Auto Insurance: \_\_\_\_\_ Phone#: \_\_\_\_\_

Claims Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Claim#: \_\_\_\_\_

Name of Adjuster: \_\_\_\_\_ MED PAY \$ LIMIT : \_\_\_\_\_ Contact Adjuster:  Y  N

Was the Accident Reported to other Auto insurance:  Y  N If yes, please fill out.

Other Auto Insurance: \_\_\_\_\_ Phone#: \_\_\_\_\_

Claims Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Claim#: \_\_\_\_\_

Do you have an Attorney?:  Y  N If yes, please fill out Attorney information

Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_

Has Attorney been contacted :  Y  N Lien:  Y  N If yes, see attached signed Lien by Attorney

**\*Patient Private Health Insurance\* If any changes in you insurance, personal information or MD, please notify front office**  
**\*\*\*\*Please attach health insurance card copies\*\*\*\***

Primary Health Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Group#: \_\_\_\_\_ Policy ID#: \_\_\_\_\_

**If there is any changes in your insurance, personal information or MD please notify front office staff.**

RELEASE OF INFORMATION/ASSIGNMENT OF INSURANCE BENEFITS/PATIENTS RESPONSIBILITY OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits for services rendered to SmithCare Therapy Center, whom I am authorizing to accept assignment. I understand that any charges for non-covered benefits or exclusions of my insurance will be my responsibility.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_