

Last Name _____ First Name _____ MI _____ M F

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Alternate Phone (____) _____ - _____ Social Security # _____

Email: _____ Family Dr. Name: _____ Family Dr. Phone(____) _____ - _____

Marital Status _____ Date of Birth: _____

EMERGENCY and/ or GUARDIAN INFORMATION:

Last Name _____ First Name _____ MI _____ Relation _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Alternate Phone (____) _____ - _____ Guardian Social Security # _____ - _____

PATIENT OR GUARDIAN EMPLOYOR INFORMATION:

Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

PRIMARY INSURANCE	SECONDARY INSURANCE	WORKER'S COMPENSATION
Insurance Co. _____	Insurance Co. _____	Claim # _____
ID # _____	ID # _____	Date of Injury: _____
Group# _____	Group# _____	Employer Name: _____
Name of Insured Person: _____	Name of Insured Person: _____	Employer Phone: _____
Insured DOB _____	Insured DOB _____	MCO _____
Insured SS# _____	Insured SS# _____	Have you seen another doctor for this injury? <input type="checkbox"/> No <input type="checkbox"/> Yes
Relation _____	Relation _____	

REFERRAL INFORMATION: How did you hear about our office? Radio TV Billboard Newspaper Website

Name of physician who referred you to our office: _____ Phone _____

Name of friend or other person that referred you to our office: _____

All information, I have filled in on this page, is accurate to the best of my knowledge. I authorize System Optics DBA, Novus Clinic to leave messages with regard to my appointments and/or medical care, on my answering machine and/or with a family member living at home. I request payment of insurance benefits to System Optics DBA, Novus Clinic for any services rendered to me or my dependent by System Optics DBA, Novus Clinic. I authorize the release of any medical information needed by my insurance company or primary care physician to process these claims. I understand that the provider's charges may exceed insurance benefits and if greater than such payments, I WILL BE RESPONSIBLE for the amount due and also for any supplies or services that are not considered an insurance benefit. If I have Medicare or (Medicare cross-over) I authorize benefits to be paid to System Optics DBA, Novus Clinic. I further understand that it is my responsibility to verify my insurance coverage. The Doctors and staff of System Optics DBA, Novus Clinic cannot guarantee and are not responsible for patient benefits, coverage amounts or lack of insurance payments. By signing below I accept that I am responsible for all payments due.

Signature _____ Date _____