

Date _____

Account Number _____



PATIENT INFORMATION

First Name _____ Initial _____ Last Name _____ Called Name _____
 Address _____ City _____ State _____ Zip _____
 Home # (____) _____ Work # (____) _____ Cell # (____) _____
 Email _____ Birth Date _____
 Social Security # _____ Marital Status (check one) M S D W Sex _____
 Work Status: Employed Retired Part-Time Student Full-Time Student Unemployed
 Employer _____

Who may we thank for referring you to us? (Please place a check next to the option)

Logan Student (Not yet an intern) Logan Employee Logan Intern Other Logan Patient First Responder
 Please tell us the NAME of the referring person _____

Event: Health Fair or Lecture at company Please tell us the name of the company/event _____
Area: Shops in plaza Works in plaza Saw sign
Advertising: Newspaper ad Radio ad Website Insurance Book (Preferred Doctor List)
Mobile Application
Other Miscellaneous _____

Name of Insurance Company _____ Insured's Name _____
 Insured's ID # _____ Insured's Date of Birth _____
 Person Responsible for paying the bills other than above _____
 Address _____
 Do you have Medicare or a Medicare Replacement? Yes No
 Emergency Contact: Name _____ Phone Number (____) _____
 Signature _____ Date _____

ACCIDENT/INJURY INFORMATION

Tell us about your major complaints and symptoms

Is today's visit related to employment? Yes No
 Is today's visit related to an automobile accident? Yes No
 Is today's visit related to another type of accident? Yes No

If you answered yes to any of the above, please give the state in which the accident occurred _____ and the date of the accident _____.

Has this ever been a problem before? Yes No If yes, give date _____

Referring physician _____

OFFICE USE ONLY

Category _____ Type of Account _____ Doctor # _____ Intern Name _____