MVA INTAKE

To help us provide the best care possible, please thoroughly complete and sign the following form. This information is confidential and will be kept as a part of your permanent record.

Patient Name: ______________________________ **Date of Birth**: ____________________
(Last) (First)

SS#:____________________ Age:_______ Sex: __________ Primary Phone #: ____________________

Email: ____

Employer:____________________________________ Occupation: ______________________________

*Female Only – Are you pregnant? __________ Due Date:____________OB-GYN: ____________________

INSURANCE COVERAGE

☐ **COPY OF CARD PROVIDED TO RECEPTIONIST**

Primary Medical Insurance

Insurance Carrier: ____________________________________ Phone: ______________________

Policy Holder's Name: ____

Policy Holder's DOB: ______________________________ Relationship to Patient: ____________________

Policy ID #: ____________________________________ Group #: ______________________________

(If you are seeking treatment as a result of an auto accident, please complete this section)

Auto/Accident Insurance: ______________________________ Date of Accident: ______________________

Patient Information (Vehicle you were in)

Auto Insurance Carrier: ______________________________ Name of Adjuster: ______________________

Involved Party Information: We do NOT accept 3rd Party Insurance

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(If you are seeking treatment as a result of an auto accident/injury sustained while on the job, please complete this section)

Workers Compensation Injury

Employer:____Phone: ______________________________

Address:____
(Street) (City) (State) (Zip)

Did you file and accident/injury report? __________ Date of Report: ____________________

Date of Injury:____________________ Time: __________________

Work Comp Carrier:______________________________ Name of Adjuster: ______________________

Phone:______________________________ Claim #: ______________________________

Assignment of Benefits:
I hereby assign and grant the benefits that I am eligible to receive for professional services rendered in this office. I authorize the release of any medical information necessary to process any insurance claims for payment. I understand that I am financially responsible for those charges not paid by my insurance.

Print Name:____________________________Signature:______________________________Date: __________