General Admittance Information

Holladay Physical Medicine/ Personal Injury Clinic

PERSONAL

NAME_____DATE_____
ADDRESS_____
CITY_____ST_____ZIP_____
HOME PHONE_____CELL PHONE_____
E-MAIL_____ (used to provide you information about your condition – exercises – health tips-Schedule appointments - Your email address will not be shared with anyone)
SS#_____
BIRTH DATE_____ AGE_____SEX_____
HT_____WT_____
MARITAL STATUS_____CHILDREN_____
EMPLOYER_____
HOW LONG?_____
ADDRESS_____
CITY_____ST_____ ZIP_____ HOURS_____
POSITION_____SUPERVISOR_____
SPOUSE_____
WK PHONE_____

EMERGENCY PERSON TO
CALL_____PHONE_____

REFERRED BY_____

May we notify your Primary Care Physician of your diagnosis and treatment? Yes No
Were you involved in an automobile accident in the past year? Yes No
Were you involved in an on the job accident in the past year? Yes No
(If you answered yes to any of these, please complete the additional underlined form)

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An office visit fee is expected at the time of service, if you do not have current insurance information and qualified coverage. All co-payments are due at the time of service.

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I will be paying today by: cash_____ check_____
credit card_____

INSURANCE INFORMATION

Please present your insurance card to a staff member!

I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment, insurance follow-up and obtaining all necessary referrals.

PATIENT' SIGNATURE_____DATE_____
GUARDIAN'S SIGNATURE_____DATE_____