



## LIEN / MED-PAY PATIENT INFORMATION

Date \_\_\_\_\_ [ ] Established Patient [ ] New Patient

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**PATIENT INFORMATION:**

Name Last: \_\_\_\_\_ First: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: [ ] Male [ ] Female

Address \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ - \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Current Employer: \_\_\_\_\_ Phone No: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver License #: \_\_\_\_\_

Name of Person to be contacted in case of emergency: \_\_\_\_\_ Phone No: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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**PERSONAL INJURY INFORMATION:**

Name of Insurance Company \_\_\_\_\_ Phone No: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Policy No: \_\_\_\_\_ Claim: \_\_\_\_\_ Adjustor: name: \_\_\_\_\_

**Auto Accident:** [ ] yes [ ] no **Lien Case:** [ ] yes [ ] no

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**ATTORNEY INFORMATION:**

Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact person: \_\_\_\_\_

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**Medical Records:** Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original

**Consent to Treatment:** I, the undersigned hereby consent to the administration and performance of all diagnostic procedures and treatments which, in the judgment of my physician/nurse practitioner, maybe considered necessary or advisable. I further agree that if I decide to leave without receiving treatment or without the consent of my physician/nurse practitioner, he/she shall not be liable for the consequences of such decision.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_