OHM PATIENT INFORMATION

Patient Name_____DOB_____ Sex_____

Address_____City_____State_____Zip_____

Home Phone_____Cell_____Work_____Ext._____

Patient social security_____ Relationship Status: S P M D W

Occupation_____ Employer_____ Spouse/Parent Employer_____

Parent's Name(if child)_____ Soc Sec#_____

Referred by_____Primary Care Provider_____
Phone

Did you receive a referral if required by your insurance? _____ Number of visits authorized_____

INSURANCE

Policy Holder's Name (if policy is under a name other than yourself. Example: a spouse or a parent's policy)

Name _____ DOB_____ Soc Sec_____

Primary Insurance _____ Address_____ Phone_____

Policy ID Number_____ Group_____

Secondary Insurance_____ Address_____

Is this a WORK RELATED INJURY? Y N Has your employer been informed? Y N

DATE OF INJURY_____ claim #_____ Adjuster_____ Phone_____

Nurse Case Manager_____ Phone_____ Attorney_____ Phone_____

Is this an injury the result of an accident? Y N Date of Accident_____ Claim #_____
MED PAY INFO _____

Co-payments and deductibles are due at the time of service. I authorize payment of medical benefits to **Osteopathic Healthcare of Maine** for services provided by Dr. Hankinson, Dr. Wu, Dr. Gilson, Dr. Hilton, & Dr. Mangalam, and do understand that I will be responsible for any balance after my claim has been submitted and processed by insurance.

_____

Signature **Date**

Can we leave messages confirming appointments on your answering machine _____