Osteopathic Healthcare of Maine

Patient Demographic Information:

Patient Name:_____ DOB:_____ Sex: M F

Address:_____City:_____State:_____ Zip: _____

Home Tel:_____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: _____Tel:_____

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:_____ Tel:_____

Policy ID Number: _____ Group: _____

Secondary Insurance:_____ Address:_____ Tel:_____

Medicare Number: _____ Companion Plan: _____

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

Date of Injury:_____ Claim #:_____ Adjuster:_____ Tel:_____

Nurse Case Manager:_____ Tel: _____ Attorney: _____ Tel:_____

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, and Dr. Greenfield, and do understand that I will be responsible for any balance remaining after my claim has been submitted and processed by insurance. I also understand that 24-hour notice of cancellation is required. If notice is not given, I may be charged a fee for missed appointment.

_____ _____

Signature **Date**

Can we leave messages confirming appointments on your answering machine? _____