PATIENT INFORMATION

Name _____ Date _____
Last Name First Name Initial

Address_____ City _____

State _____ Zip _____ Email: _____

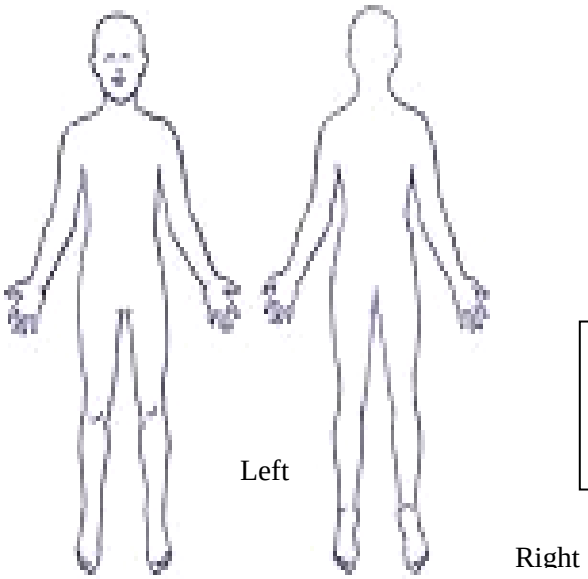
SS#: _____ Date of Birth _____ Age _____

Home Phone _____Cell Phone _____Work Phone_____

Sex: Male/ Female (please circle) Single/Married/Widowed/Separated/Divorced

Name Insurance_____ Insurance Ph # _____ID_____

Group # _____ Whom May we Thank for referring you? _____



Patient Symptom Pain Drawing

Mark on your body where you are experiencing pain now.

X = Burning A = Aching N = Numbness
0 = Pins and Needles S = Stabbing

Please mark on the line how your condition is now.

No pain Worst pain
0 1 2 3 4 5 6 7 8 9 10

PATIENT ACKNOWLEDGEMENT

Please read and sign the following responsibility and consent. To the best of my knowledge the above information is true and correct. I understand I am responsible for any financial obligation incurred for the services provided. If I am a Medicare beneficiary I have been advised this facility does not participate with the program and that I will be responsible for any and all treatment. I further understand that Medicare does not reimburse me for these services. I also authorize and request services for myself and or my dependents. I give consent to any advisable and necessary procedures and injury assessment to be administered by the attending physician and or by his supervised staff. I understand I will be informed of all services and their estimated cost before any services are rendered. Verification of insurance benefits are only an estimate and does not guarantee payment. Boca Medical Therapy is not responsible for any errors represented by your insurance. This is a direct assignment of insurance benefits. By signing below I am agreeing to these terms and verify that I have read this statement.

_____

Signature (and relationship if for child) Print Name Date