_____Insurance cards copied

Date: _____

Account# _____

Patient Intake Form

Insurance # _____

Please **PRINT** and complete all sections.

Co-Pay $ _____

Patient Personal Information

Name: (Last)_____ (First) _____ (Middle)_____ (Age.)_____

Street Address: _____ Apt# _____ City: _____ State: _____ Zip: _____

Home Phone:_____ __Pager or Cell: _____ Date of Birth:_____ Sex: ☐Male ☐Female

Social Security #: _____ Email: _____ Driver's License # _____ State: _____

Work phone: _____ Ext.: _____ Occupation: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated Spouse's Name:_____

Is your condition a result of a work injury? ☐ YES ☐ NO an auto accident? ☐ YES ☐ NO **Date of Injury?** _____

How do you wish to be addressed (Preferred Nickname?) _____

Patient's/Responsible Party Information

Responsible party:_____ Date of Birth: _____ Social Security #: _____

Relationship to Patient: ☐Self ☐Spouse ☐Other _____ Home phone: _____ Work phone: _____

Employer: _____ ☐Full Time ☐Part Time ☐Retired ☐Not Employed Student: ☐Full Time ☐Part Time ☐No

Address: _____ City: _____ State:_____ Zip: _____

Spouse's Employer: _____ Spouse's Work #:_____

Address: _____ City: _____ State:_____ Zip: _____

Patient's Insurance Information *Please present insurance card to receptionist.*

Name of PRIMARY insurance _____--**For Work or Auto Injury - Claim #:**_____

Address:_____ _____ City:_____State: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____ Relationship to Insured: _____

Policy #: _____ Group #: _____

*****Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substation for payment. Some companies pay fixed allowances for certain procedures; others pay a percentage of the charge. It is your responsibility to pay any co-insurance, deductible or any other balance not paid for by your insurance.**

Patient's Referral Information

Referred by: _____ If referred by a friend, may we thank him or her? ☐ YES ☐ NO

Name(s) of other physician(s) who care for you: _____

_____

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____ City: _____ State:_____ Zip: _____

Home Phone:_____ Work Number: _____

Assignment of Benefits ~ Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to ***Dr. Wayne M. Latimer &/or the IROC Corp.,*** and any assisting physicians, for services rendered whether payment is from insurance carrier or attorney. I understand that I am completely financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of such benefits. I further agree that this document shall be legal and biding to any attorney I may be working with, or any that may yet be hired, and that a photocopy of this agreement shall be as valid as the original.

Patient Signature:_____Date:_____

Method of payment: ☐ CASH ☐ CHECK ☐ CARD

IROC ~ ps

Dr. Latimer's Integrative Rehab,
Occupational and Sports Medicine

 603 N. Mission St. -- Wenatchee, WA, 98801 - Phone: (509) 884 - HELP ! (4357) - Fax : (509) 888 – 4601