General Admittance Information

Holladay Physical Medicine/ Personal Injury Clinic

PERSONAL

NAME_____DATE_____
ADDRESS_____
CITY_____ST_____ZIP_____
HOME PHONE_____CELL PHONE_____
E-MAIL_____ (used to provide you information about your condition – exercises – health tips-Schedule appointments - Your email address will not be shared with anyone)
SS#_____
BIRTH DATE_____ AGE_____SEX_____
HT_____WT_____
MARITAL STATUS_____CHILDREN_____
EMPLOYER_____
HOW LONG?_____
ADDRESS_____
CITY_____ ST_____ ZIP_____ HOURS_____
POSITION_____SUPERVISOR_____
SPOUSE_____
WK PHONE_____

EMERGENCY PERSON TO
CALL_____PHONE_____

REFERRED BY_____

May we notify your Primary Care Physician of your diagnosis and treatment? Yes No
Were you involved in an automobile accident in the past year? Yes No
Were you involved in or subjected to head trauma in the past year? Yes No
(If you answered yes to any of these, please be sure to notify the doctor0

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All service fees are expected at the time of service.

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I will be paying today by: cash_____ check_____
credit card_____

INSURANCE

We do not accept insurance assignment but will file electronically for you if you present your insurance card! All fees for services must be paid at the time of service.

I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment, insurance follow-up and obtaining all necessary referrals.

PATIENT' SIGNATURE_____DATE_____

GUARDIAN'S SIGNATURE_____DATE_____