PATIENT INFORMATION **PLEASE PRINT LEGIBLY**

Last Name	First Name		M.I.
Street	City	State	Zip Code
Home Phone ( )	Cell Phone ( )		
Work Phone ( )	Email		

Birth Date	Age	Social Security #	Sex	Marital Status	__Single __Widowed __Married __Divorced

If Married – Name of Spouse; If Minor – Name of Parent Address Phone

Person to Contact in an Emergency Relationship Address Phone

EMPLOYMENT INFORMATION

_____Patient _____Parent	Name		
Place of Employment	Occupation		
Address	City		
State & Zip Code	Phone		

MISC. INFO

Name of Pharmacy	Phone
Address	
Name of Attorney	Phone
Address	

INSURANCE INFORMATION

Name of Insured DOB SS#			Name of Insured DOB SS#		
Primary Insurance Company		Phone	Secondary Insurance Company		Phone
Address			Address		
City	State	Zip Code	City	State	Zip Code
Policy #/ID#/Carrier Case#	Group #/WCB#		Policy #/ID#/Carrier Case#	Group #/WCB#	

ACCIDENT INFORMATION **IF APPLICABLE**

Date of Accident	_____Automobile	_____Work Related

I hereby authorize and give my consent to Dr. Thomas Eagan to provide me, or _____ (the "Patient") medical care and treatment, including performing diagnostic tests (e.g. x-rays, EKG's), routine evaluations, consultations and physical examinations and the administration of such medications and the providing of such medical treatments as may be prescribed, or deemed necessary or advisable.

ASSIGNMENT OF BENEFITS – RELEASE OF INFORMATION

I hereby authorize my physician to release any information regarding my medical condition, including disability or employment related information concerning my insurance carrier(s), authorized agent(s), or attorney(s) for the purpose of validating and determining benefits payable in connection with my incurred medical expenses. I understand that I or my authorized representative may receive a copy of the authorization upon request. I also authorize direct payment of benefits.

I understand that I am financially responsible for all charges whether or not covered by insurance.

SIGNATURE_____ **DATE**_____