



9800 Broadway Ext. • Oklahoma City, OK 73114 • Phone 405.427.6776

## PATIENT INFORMATION

(Please Print – Fill in All Blanks)

Patient's Legal Name:		Last	First	M.I.	Sex:	DOB:	Age:
Social Security Number:				Marital Status:			
				<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
Patient's Address:				Employment Status:			
				<input type="checkbox"/> Employed <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student <input type="checkbox"/> Retired			
City:	State:	Zip Code:	Email:		Referring Physician:		
Home Phone:	Work Phone:		Cell Phone:				
Ethnicity:		Race:			Preferred Language:		
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Declined		<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Pacific <input type="checkbox"/> Native American			<input type="checkbox"/> Multiple <input type="checkbox"/> Other		

### INSURANCE INFORMATION – We will need a copy of your insurance card in order to file a claim.

Name of Primary Insurance Company	
Policyholder Name	Relationship to Patient
Policyholder DOB	Policyholder SSN
Policyholder Employer	
Secondary Insurance (if applicable)	
Policyholder Name	Relationship to Patient
Policyholder DOB	Policyholder SSN
Policyholder Employer	

### EMPLOYMENT INFORMATION

Patient's Employer	Phone Number
Insured Employer	Phone Number

### If the patient is a minor, please list both parent names and employers

Mother	Employer	Phone Number
Father	Employer	Phone Number

### NEXT-OF-KIN INFORMATION

Nearest relative (or friend, not spouse), not living with you:	
Home Phone:	Relationship to Patient:

### WHO REFERRED YOU TO OUR OFFICE? (circle one)

Adjustor	Attorney	Billboard	Case Manager	Doctor	Employer	Friend	Hospital	Insurance
Magazine	Neighbor	Phone Book	Physical Therapist	Coach	Radio	School	Trainer	Other

### THIRD PARTY BILLING (circle one)

Is your injury work related?	YES	NO
Is this injury due to an accident?	YES	NO
If your injury is MVA related have you obtained an accident report?	YES	NO

I hereby authorize my insurance to be paid directly to the facility and the physician. I acknowledge that I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge & agree that I have received a copy of the TPG Privacy Notice.

Signature:	Date:
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