

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ M.I.: \_\_\_\_\_  
 Patient SS #: \_\_\_\_\_ Date of Birth (MM/DD/YYYY): \_\_\_\_\_  Married  
 Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  Single  
 Reason for visit: \_\_\_\_\_  Male  Female  
 Patient e-mail address: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Primary care physician name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Employer name: \_\_\_\_\_  
 Employer address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

How did you learn about Concentra? (Check one, please.)

- Billboard  Direct mail  Doctor referral  Driving by  Employer  Existing patient  Friend/relative  
 Insurance company  Internet  Movie theater  Newspaper  Phone book  Radio  Pharmacy  
 School  Apartment Complex

### Today's Payment

*How will you be paying for today's bill?*

Payment made today will be paid by:

- Patient Pay—I will be paying today using:  Cash  Check  VISA  MasterCard  Discover  Debit card  
 My company—I am participating in a program that is company-paid.  
 Insurance—I will present my insurance card and an approved form of ID. (Please complete next two sections.)

### Insurance Information

*If you're using insurance to pay today's bill, please provide this information...*

Employer of insured person: \_\_\_\_\_  
 Insurance carrier: \_\_\_\_\_  
 Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Claims address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Do you have insurance with more than one health plan?  Yes  No  
 If yes, name of other insurance carrier: \_\_\_\_\_  
 ➔ (Please present both ID cards at check-in.)

### Account Information

*If you're using insurance, this is information about the person carrying the insurance...*

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ M.I.: \_\_\_\_\_  
 Account SS #: \_\_\_\_\_ Date of birth (MM/DD/YYYY): \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Relationship to patient: (Check one, please.)  Self  Spouse  Parent/Guardian  Other: \_\_\_\_\_

I certify that the information provided is correct to the best of my knowledge. I will not hold Concentra, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for trusting us with your care today.