V Stephen Slana MD SC

PLEASE PRINT NEATLY

	TODAY'S DATE:

SECTION A

PATIENT DEMOGRAPHICS

LAST NAME:		**HOME PHONE #:** ( )	
FIRST NAME:	**M.I.:**	**WORK PHONE #:** ( )	**EXT#**
PHYSICAL STREET ADDRESS:		**CELL PHONE #:** ( )	
MAILING ADDRESS:		**DATE OF BIRTH:**	
CITY:	**STATE:**	**SOCIAL SEC#:**	
ZIP CODE:	**SEX: M / F**	**MARITAL STATUS: Married Single Widowed Divorced**	
EMPLOYED: YES / NO / RETIRED		**REFERRING PHYSICIAN'S FIRST AND LAST NAME:**	
EMPLOYER:		**FIRST NAME:**	
JOB TITLE:		**LAST NAME:**	
E-MAIL ADDRESS:		**REF. PHYSICIAN'S PHONE #:** ( )	

REASON FOR TODAY'S VISIT (YOUR MAJOR COMPLAINT)

EMERGENCY CONTACT NAME:			
EMERGENCY PHONE #:		**RELATION TO YOU:**	

Is today's visit due to a WORKERS' COMPENSATION injury? YES / NO

If yes, please complete all questions in Section C on Page 3 of this document.

Is today's visit due to a MOTOR VEHICLE ACCIDENT / or personal injury caused from a third party? YES / NO

If yes, please complete all questions in Section D on Page 3 of this document.

ATTENTION PATIENTS: ALL DEDUCTIBLE AND COPAY AMOUNTS ARE DUE AT THE TIME OF SERVICE.

***** WE ACCEPT VISA, MASTERCARD, DISCOVER, PERSONAL CHECKS AND CASH *****

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SECTION B

BILLING INFORMATION

IF YOUR CARD WAS COPIED, PLEASE SIMPLY FILL IN THE ** AREAS OF SECTION B

(1) PRIMARY HEALTH INSURANCE INFORMATION:	(2) SECONDARY HEALTH INSURANCE INFORMATION
**Insurance Name:	**Insurance Name:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:
Phone#:	Phone#:
Group Name or #:	Group Name or #:
Insured Party ID#:	Insured Party ID#:
Policy Date Effective:	Policy Date Effective:
**Who's Insurance is this: Self / Spouse / Parent	**Who's Insurance is this: Self / Spouse / Parent
**If Spouse or Parent, their name:	**If Spouse or Parent, their name:
**Insured's Date of Birth: (REQUIRED)	**Insured's Date of Birth: (REQUIRED)
**Insured's Employer:	**Insured's Employer:
**Is this an employer insurance plan? YES / NO	**Is this an employer insurance plan? YES / NO

(3) TERTIARY HEALTH INSURANCE INFORMATION:
**Insurance Name:
Street Address:
City, State, Zip:
Phone#:
Group Name or #:
Insured Party ID#:
**Who's Insurance is this: Self / Spouse / Parent
**If Spouse or Parent, their name:
**Insured's Date of Birth: (REQUIRED)

Is this an employer insurance plan? YES / NO

SECTION C

WORKERS' COMPENSATION INFORMATION:

IN ORDER FOR OUR OFFICE TO BILL YOUR CLAIM, EACH OF THE FOLLOWING QUESTIONS MUST BE ANSWERED.

1. Have you filled out an accidental injury report with your employer? YES / NO
2. What is your date of injury? (REQUIRED, MUST BE EXACT)
3. How did this injury happen? Please describe:
4. What is the name, address and phone # of your work/comp carrier you would like us to bill? (REQUIRED)

Name:

Street Address:

City, State, Zip

Phone:

5. What is your claim number? (REQUIRED)
6. What is your adjuster's name?
7. What is his/her direct phone #?

SECTION D

PERSONAL INJURY INFORMATION:

IN ORDER FOR OUR OFFICE TO BILL YOUR CLAIM, EACH OF THE FOLLOWING QUESTIONS MUST BE ANSWERED.

1. Date of accident? (REQUIRED, MUST BE EXACT)
2. Were you "on the clock" for WORK at the time of this accident? YES / NO (If yes, then work/comp is billed first.)
3. Please describe how this accident occurred:

3. Was anyone ticketed in this accident? YES / NO

   If yes, who was ticketed? I was ticketed / The other party was ticketed / We both were ticketed

4. Name, Address, Phone # of the car insurance of the vehicle YOU were in: (REQUIRED)

   Ins. Name & Address:

   Phone #:

5. Name, Address, Phone # of the car insurance of the OTHER PARTY: (REQUIRED) Name of other party:

   Ins. Name & Address:

Phone #:	
6. What is your claim number? (REQUIRED)	
7. Who is your adjuster?	Adjuster's Phone #: