Name: ________________ **Date of Birth:** ____________ **Age:** ______
Address: ________________ **Social Security#:** ____________ **Sex:** ( ) M ( ) F
City, State, Zip: ________________ **Marital Status:** ( )Married ( )Single ( )Divorced ( )Widowed
Home Phone: ________________ **Referring Provider:** ________________
Cell Phone: **Email Address:**

PATIENT EMPLOYMENT INFORMATION:
Employer's Name: ________________
Employer's Phone: ________________
Occupation: ________________

EMERGENCY CONTACTS
Name: ________________
Relationship: ________________
Phone: ________________

RESPONSIBLE PARTY **(if patient is under 18 years of age)**
Name: ________________ **Employer:** ________________
Address: ________________ **Home Phone:** ________________
City, State, Zip: ________________ **Work Phone:** ________________
Date of Birth: ________________ **Social Security #:** ________________

PRIMARY INSURANCE
Ins. Co. Name ________________
ID#: ____________ **Group#:** ____________
Subscriber's Name: ________________
Subscriber's Date of Birth: ________________

SECONDARY INSURANCE
Ins. Co. Name ________________
ID#: ____________ **Group#:** ____________
Subscriber's Name: ________________
Subscriber's Date of Birth: ________________

Is current problem related to:
A work injury? ____ Yes ___ No
A vehicle accident? ____ Yes ___ No

How did you hear about us?
Internet __________ **Friend/Family member** ________
Physician/Provider: ________________

____ I have read/understand TOJR's financial policy. I understand that I am ultimately responsible for all charges incurred by me.
___ I authorize TOJR to release any medical information required by my insurance company or worker's compensation carrier for the processing of any medical claims filed on my behalf.
___ I understand photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that these images will be stored in a secure manner. Images that identify me will not be released without written authorization from me or my legal representative only if they are released for purposes other than treatment, payment, or healthcare operations.
___ I acknowledge that I have received TOJR's Notice of Privacy Practices, which describes how medical information about me may be used and disclosed.
___ I agree that TOJR may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.
By initialing here, I give TOJR permission to send TEXT reminders of my appointments to my cell phone OR permission to call my cell phone with automated appointment reminders. If I leave this line blank, no permission is given.
___ **I give permission for TOJR to speak to the following people regarding my medical and/or billing information (write below):**

____

________________________ ________________________
Patient/Guardian Signature Date

RACE/ETHNICITY/LANGUAGE (We are required to -you may choose "refused" if you don't wish to answer):
1. RACE: ___ American Indian or Alaska Native ___ Asian ___ Black or African American
___ Native Hawaiian or other Pacific Islander ___ White ___ Refused
2. ETHNICITY: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Refused
3. PREFERRED SPOKEN LANGUAGE (please write in):