

Gary R. Rombough, M.D., P.A.

PLEASE COMPLETE BOTH SIDES

Date \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Telephone #: \_\_\_\_\_

EMERGENCY CONTACT INFORMATION:

Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ Telephone # \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

INSURANCE INFORMATION:

Insurance #1

Insurance Company Name \_\_\_\_\_ ID#: \_\_\_\_\_

Address: \_\_\_\_\_ Group #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Group #: \_\_\_\_\_

Telephone\*: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Print Name of Subscriber: \_\_\_\_\_ Subscriber Birthdate: \_\_\_\_\_

Social Security # of Subscriber: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance #2

Insurance Company Name \_\_\_\_\_ ID#: \_\_\_\_\_

Address: \_\_\_\_\_ Group #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Group #: \_\_\_\_\_

Telephone\*: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Print Name of Subscriber: \_\_\_\_\_ Subscriber Birthdate: \_\_\_\_\_

Social Security # of Subscriber: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

(Over Please)

Part of body involved (include R or L) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of injury or onset of problem \_\_\_\_\_

Known Medical Problem \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies \_\_\_\_\_

Current Medication \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you use tobacco? \_\_\_\_\_ How much per day? \_\_\_\_\_

Do you use alcohol? \_\_\_\_\_ How much per week? \_\_\_\_\_

Do you misuse or have you misused drugs? \_\_\_\_\_

Please Detail \_\_\_\_\_

Is your injury work related? \_\_\_\_\_

Is your injury related to a motor vehicle accident? \_\_\_\_\_

If so, please fill in below:

Name of your car insurance \_\_\_\_\_

Agent \_\_\_\_\_

Agent's Address \_\_\_\_\_

*I will pay for today's visit by*    *Cash* \_\_\_\_\_    *Check* \_\_\_\_\_    *Credit Card* \_\_\_\_\_

I hereby assign to Dr. Rombough all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

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

I authorize the release of my medical information for treatment, payment or healthcare operational purposes.