

Burkam & Associates

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____
Address _____
Address2 _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ SSN _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____
First Name _____ Phone _____

Employer

Name _____ Phone _____
Address _____
Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit _____
Referred By _____ Primary Care Physician _____
Latest Referral Information _____ Motor Vehicle Accident _____
Latest Plan of Care _____ That occurred in: _____
Notes: _____

Primary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____ CoPay _____	Coinsurance _____	Date of Birth _____

Secondary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____ CoPay _____	Coinsurance _____	Date of Birth _____

Tertiary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____ CoPay _____	Coinsurance _____	Date of Birth _____

I do hereby consent to such treatment by the authorized personnel of Burkam & Associates as may be dictated by prudent medical practice by my injury or condition. This consent is intended as a waiver of liability for such treatment.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Burkam & Assoc. Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the company in writing.

Signature: _____ Date: _____