C. PHILIP O'CARROLL, M.D.
PATIENT INFORMATION

Referred By: DOCTOR, FACILITY or PCP-IF SELF REFERRED: (Please enter ***COMPLETE*** Name & Address) ____________________

Patient	Last Name	First Name	Middle Name	Age	Today's Date
Address	Street	City	State	ZIP Code	Social Security Number
☐ Female ☐ Male	Birth Date ***Req***	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Driver's License Number	Home Phone	
Race	Language	Ethnicity	e-mail address		
Employed? ***REQ***	Employer Name & FULL Address ***REQUIRED***			Work Phone	
Occupation - ***Indicate if Student***	Work/Student Status-CIRCLE ONE ***Required*** Full Time Part-Time Retired	Former Patient?_______ When?		Cell Phone	

Which Phone Number would you like us to contact you? Pls. Circle: ***H****ome* ***W****ork or* ***C****ell*

RESPONSIBLE PARTY (If other than patient, please fill out completely)					Social Security Number
Relation to Patient ☐ Spouse ☐ Parent ☐ Guardian	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				Birth Date
Name	Last Name	First Name	Middle Name		Home Phone
Address	Street	City	State	ZIP Code	Work Phone
Employer Name & FULL Address					Cell Phone

PERSON TO CONTACT IN CASE OF EMERGENCY - ***REQUIRED***

Please PRINT	Name	Relationship	Phone Number

IF YOU WERE INJURED, were you injured

☐ On your job? If so, did you notify your employer? _____________

☐ In an auto accident? ☐ At home?

DATE OF INJURY ______________________ STATE________ ☐ During Recreation Other __________________________

Adjuster, Attorney, Auto Insurance, ETC…____

NOTE TO PATIENT: What kind of insurance do you have (circle which) **PPO HMO Medicare Other**__________

Failure to do so may greatly reduce the benefits YOU may be entitled to.

INSURANCE INFO - Primary Insurance Company				Insured	
Address	Street	City	State	ZIP Code	Group Number	Subscriber's Number
Secondary Insurance Company				Insured	
Address	Street	City	State	ZIP Code	Group Number	Subscriber's Number

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to the doctor rendering service. I understand that I am financially responsible for the charges not covered by the assignment. A photostat of this authorization is accepted with the same authority as the original. I hereby authorize the doctor rendering service to release any information required in the course of my examination or treatment.

INSURED'S SIGNATURE - ***Required*** ____________ **Date** ____________ **SIGNED: Patient or Parent of Minor** ____________