

# Richard T. Dauphiné, MD

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## Patient Information

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Area To Be Examined: \_\_\_\_\_ Please Circle One:      New Patient      Returning Patient

Marital Status:    Married                  Single                  Divorced                  Widowed                  Sex:    Male                  Female

SSN: \_\_\_\_\_ Occupation: \_\_\_\_\_ Wk. Tel.: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employed By: \_\_\_\_\_ Wk. Tel.: \_\_\_\_\_

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## Emergency Information

Nearest Friend or Relative Not Living With You: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Tel.: \_\_\_\_\_

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## Account Information – Person Responsible for Account

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Employer: \_\_\_\_\_ Wk. Tel.: \_\_\_\_\_

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## Insurance Information

DATE OF INJURY: \_\_\_\_\_ How?: \_\_\_\_\_ Where?: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Policy / Group #: \_\_\_\_\_

Name of Insured Person: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

## Workers' Compensation Information (if applicable)

Name & Address of Carrier: \_\_\_\_\_

Employer at Time of Injury: \_\_\_\_\_

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## Who may we thank for referring you to us?

Name & Address: \_\_\_\_\_

Is any other member of your family a patient in our office?: \_\_\_\_\_

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**I understand that I am responsible for charges incurred for services rendered, with copayments due at the time of the visit.**

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**Signature of Patient or Legal Guardian**

**Date**