IDENTIFICATION SHEET

NAME ______________________________ OFFICE ______________ TIME ______________

ADDRESS ______________________________________ AGE ______ SEX ______________

______________________________________ ZIP CODE ______________

TELEPHONE ____________________ CELL# __________________ DATE OF BIRTH ____________

SOCIAL SECURITY # ________________ MARITAL STATUS ______ RIGHT HANDED ____ LEFT HANDED ____

OCCUPATION ________________________ EMPLOYER ______________________________

ADDRESS ____ ZIP CODE ____________

TELEPHONE ______________________________ CAN WE CONTACT YOUR WORK? YES NO

REFERRING DOCTOR (NAME & ADDRESS) ______________________________________

HOW DID YOUR INJURY HAPPEN? (PLEASE CIRCLE ONE)

AUTO WORK RELATED SLIP & FALL OTHER

DATE OF ACCIDENT ________________ ACCIDENT LOCATION (CITY/TOWN) ______________________

ATTORNEY'S NAME ________________________________ TELEPHONE ____________________

PLEASE CIRCLE ONE: I AM MEDICARY BENEFICIARY: YES NO

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
NAME ______________________	NAME ______________________
ADDRESS ______________________	ADDRESS ______________________
______________________	______________________
TELEPHONE ______________________	TELEPHONE ______________________
CLAIM # ______________________	CLAIM / ID # ______________________
POLICY # ______________________	POLICY / GROUP # ______________________
ADJUSTER ______________________	SUBSCRIBER ______________________
INSURED ______________________	EFFECTIVE DATE ______________________

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN: I HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER TO PAY DIRECTLY TO ALLIED HEALTH CTR., ALL FEES OUT OF ANY BENEFIT OR INDEMNITY DUE ME UNDER THE TERMS OF MY POLICY, AND RECOGNIZE THAT PAYMENT IN THIS MANNER IS THE SAME AS PAYMENT TO ME. PAYMENT IS AUTHORIZED UPON YOUR RECEIPT OF THIS ITEMIZED STATEMENT FOR SERVICES RENDERED TO ME. THIS POLICY WAS IN FULL FORCE AND EFFECT AT THE TIME THAT SERVICES WERE RENDERED. PAYMENT OF THIS AMOUNT IS HEREIN DIRECTED IN WHOLE OR IN PART, SHALL BE CONSIDERED THE SAME AS IF PAID BY YOUR COMPANY DIRECTLY TO ME. THIS ALSO AUTHORIZES ALLIED HEALTH CTR., TO RELEASE INFORMATION REGARDING MY ILLNESS TO MY REFERRING PHYSICIAN, ATTORNEY, AND INSURANCE COMPANY. I ASSIGN ALL MY RIGHTS, TITLE, AND INTEREST IN ANY SUCH BENEFIT TO ALLIED HEALTH CTR., AND THIS ASSIGNMENT IS IRREVOCABLE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY UNPAID BALANCE TO ALLIED HEALTH CTR., FOR MEDICAL SERVICES RENDERED TO ME BY ALLIED HEALTH CTR.,

DATE ________________ PATIENT'S SIGNATURE ______________________________

PRINT NAME ______________________________

IF TRANSLATED, SIGNATURE OF TRANSLATOR:

DATE ________________ TRANSLATOR'S SIGNATURE ______________________________