# Lynne Chadfield DO PLLC

**Today's Date:** _____

Patient's Legal Name: _____
Last First Middle

Birth Date: _____ Age: _____

Address: _____
Street City State Zip

Patient's SS # _____ -_____ -_____ Home Phone # ( _____ ) _____ -_____ Cell #: (_____) _____

Please Circle: Married / Single / Divorced / Widowed / Separated Please Circle: Male / Female

Patient's Employer _____( _____) _____
Name Address Phone

Referring Doctor _____( _____) _____
Name Address Phone

Next of Kin / Spouse _____ Relationship _____

Next of Kin / Spouse Home Phone ( _____ ) _____ -_____ Work Phone ( _____ ) _____ -_____

Primary Care Physician_____( _____) _____ -_____
Name Address Phone

Pharmacy _____( _____) _____ -_____
Name Address Phone

## INSURANCE INFORMATION

**Primary Insurance** _____

Name of cardholder _____

SS # _____ Birth date _____

Group # _____ Contract # _____

Insurance phone # ( _____ ) _____

Employer of cardholder _____

Employer phone # ( _____ ) _____

**Secondary Insurance** _____

Name of cardholder _____

SS # _____ Birth date _____

Group # _____ Contract # _____

Insurance phone # ( _____ ) _____

Employer of cardholder _____

Employer phone # ( _____ ) _____

**Medicare #** _____ **Medicaid #** _____

**WORKMAN'S COMPENSATION:** □ Yes □ No

Date of Injury _____ Claim # _____

Work Comp Ins. _____

_____( ____ ) _____
Address Phone

Contact person _____( ____ ) _____
Name Phone

Attorney involved? _____( ____ ) _____
Name Phone

**Auto Accident:** □ Yes □ No

Date of Injury _____ Claim # _____

Auto Ins. _____

_____( ____ ) _____
Address Phone

Contact person _____( ____ ) _____
Name Phone

Attorney involved? _____( ____ ) _____
Name Phone

**What insurance will be responsible for today's visit?** _____

**If patient is under the age of 18, name of parent accompanying patient:** _____