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## WELCOME BACK

Please update the following information  
so that our records are accurate. Thank you!

ABOUT YOU	Today's Date: ____/____/____ Name: _____ Street Address: _____ City: _____ State: ____ Zip: _____ S.S.#: ____/____/____ Drivers License #: _____ Birth date: ____/____/____ <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow Home Phone: _____ Pager / Cellular: _____ Work Phone: _____ Which number is best used to reach you/leave a message? _____ Employer: _____ Occupation: _____ Employers Address: _____ City: _____ State: ____ Zip: _____
SPOUSE	Spouse Name: _____ Birth date: ____/____/____ S.S.# ____/____/____ Spouse Employer: _____ Phone: _____ Occupation: _____ Spouse Insurance Co.: _____ Phone: _____ Policy No: _____
PATIENT INSURANCE INFORMATION	Please check any and all insurance coverage you or your spouse have, that is applicable in this case. <input type="checkbox"/> Major Medical <input type="checkbox"/> PPO/HMO <input type="checkbox"/> Auto Accident <input type="checkbox"/> Work Injury <input type="checkbox"/> Other _____ <input type="checkbox"/> Medicare I.D.# _____ <input type="checkbox"/> Medicaid I.D.# _____ Name Of Insured: _____ Relationship To Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____ Insurance Co. Name: _____ Adjuster: _____ DOA: _____ <b>PLEASE BRING INSURANCE CARD AND DRIVERS LICENSE TO THE FRONT DESK TO COPY</b>
REASON FOR YOUR VISIT	Reason For Your Visit: _____ Are you seeking treatment in connection with an auto accident? _____ <b>If Yes, please obtain Auto Accident forms from the office.</b>
HEALTH INFORMATION	Please List, And Give Dates Of Any Serious Medical Conditions Or Surgeries You Have Had: _____ Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Do You Take? <input type="checkbox"/> Muscle Relaxers <input type="checkbox"/> Pain Killers <input type="checkbox"/> OTC List Other Drugs That You Take: _____
PATIENT AGREEMENT	<b>ASSIGNMENT AND RELEASE</b> I, The undersigned, have insurance coverage with _____ Name of Insurance Company and assign directly to Dr. Hudson all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. _____ Signature of Insured/Guardian _____ Date _____