## Patient Information

Patient Name: ____________________________________________________ Date:________________
Last First MI

Address: ______________________________________________________________________________
Street City State Zip
E-mail address: ____________________________________________
Phone Number: Home:(_____)_______________________________
Cell: (_____)________________________________
Work:(_____)________________________________
Which Number would you like us to contact you: ____________________
Date of Birth: _____________________________
Male: ________Female:________Married:________ Single:_______Student: Y N
Social Security Number: ____________________________
Employer:_________________________________________Occupation:_______________________
Referring Health Care Provider: ____________________________
Primary Care Provider: ___________________________________
Who should we contact in case of an emergency? ________________________Phone: ______________
How did you hear of "The Finley Center, LLC" and whom may we thank: ________________________

**Please initial below to indicate you have received and agree to Finley Center policies:** Initial Below:
I have read, understand, and agree to terms listed in the 'Consent To Treat' document: _____________
I have read, understand, and agree to terms listed in the 'Financial/Office' document: _____________
I have read, understand, and agree to terms listed in the 'Privacy Notice' document: _____________

## Insurance Information

***Please provide our office with a copy of any active insurance card***

**Primary Insurance**: ___________________________Insurance phone #:_________________________
ID#:____________________________________Group#:______________________________

**Secondary Insurance**: ________________________Insurance phone#: __________________________
ID #: ____________________________________Group#: ______________________________

### By Signing Below:

I authorize The Finley Center to release any information that they, my physician or insurance company may request regarding my present injury or illness. I do herby consent to such treatment by the authorized personnel of The Finley Center as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence. A copy of this assignment shall be considered as effect and valid as the original.

Patient Signature:__________________________________________________Date:___________________
(Signed by parent or guardian if under 18 years of age)

6490 South McCarran Blvd. #F-52 Reno NV 89509 Phone: (775)337-1334 Fax: (775)337-1336