SoftWave
Tissue Regeneration Technologies

DATE:

FULL NAME: (FIRST/MIDDLE/LAST)			DATE OF BIRTH:	
EMAIL:	GENDER AT BIRTH:		GENDER ID/PRONOUN:	
ADDRESS:		CITY:	STATE:	ZIP:
HOME PHONE:	CELL:		WORK:	
OCCUPATION:	EMPLOYER:			
	EMPLOYER ADDRESS:			
EMERGENCY CONTACT:		RELATIONSHIP:	PHONE:	
MARITAL STATUS: SINGLE / MARRIED / DOMESTIC PARTNER / DIVORCED / SEPARATED / WIDOWED				
SPOUSE/PARTNER NAME:		EMPLOYER:		
WHO REFERRED YOU TO THE RUSSELL CENTER?				

HEALTHCARE

PRIMARY CARE DOCTOR:	ADDRESS:	PHONE:
		FAX:
PAYMENT RESPONSIBILITY:		PHONE:
ADDRESS:		
HEALTH INSURANCE CARRIER:		ID: GROUP:
IS THIS VISIT A RESULT OF AN ACCIDENT? YES / NO	WORK / AUTO / OTHER:	INJURY DATE:
THIRD PARTY INSURER:	ADJUSTER:	PHONE:
CLAIM NUMBER:	ATTORNEY:	PHONE:
HAVE YOU BEEN TREATED FOR THIS CONDITION IN THE PAST? YES / NO		
TREATING PROVIDERS:		PHONE:

I understand that Health/AccIdent insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me are my personal financial responsibility for timely payment. Any and all charges unpaid by my carrier after 90 days become my responsibility and are due upon receipt.

PATIENT SIGNATURE:	DATE:
NAME OF INSURED:	
SIGNATURE OF LEGAL GUARDIAN OR RESPONSIBLE PARTY:	
NAME OF RESPONSIBLE PARTY:	DATE:

We take care of the most important piece of equipment you own…YOU!