TODD B. GUTHRIE, M.D. *** THOMAS E. DANIEL, M.D.
635 LASSEN LANE, MT. SHASTA, CA 96067
(530) 926-5211

YOUR NAME: ______________________ DATE OF BIRTH: ______________ SS#: ______________

MAILING ADDRESS: ______________________ PHYSICAL ADDRESS: ______________________

MALE or FEMALE (circle one) SINGLE/MARRIED/WIDOWED/DIVORCED (circle one)

HOME PHONE: ______________________ BUSINESS PHONE: ______________________

CELL PHONE: ______________________

WHO REFERRED YOU HERE? ______________________ FAMILY DOCTOR'S NAME: ______________________

DATE OF INJURY OR ACCIDENT: ______________________

PRESENT EMPLOYER: ______________________ OCCUPATION: ______________________

EMPLOYER'S ADDRESS: ______________________ EMPLOYER'S PHONE: ______________________

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME: ______________________ PHONE: ______________________

RELATIONSHIP TO PATIENT: ______________________

PERSON RESPONSIBLE FOR PATIENT'S BILLS (if other than patient):

NAME: ______________________ PHONE: ______________________

ADDRESS: ______________________ SOCIAL SECURITY#: ______________________

RELATIONSHIP: ______________________

INSURANCE INFORMATION:

IS THIS A WORK RELATED INJURY? YES or NO (circle one) EMPLOYER AT TIME OF INJURY: ______________________

WORKERS' COMP CARRIER: ______________________ ADDRESS: ______________________

CLAIM #: ______________________

DATE OF INJURY: ______________________ ADJUSTOR NAME: ______________________

PRIMARY INSURANCE: ______________________ ID#: ______________________

SUBSCRIBER'S NAME (if other than pt): ______________________ RELATIONSHIP TO PATIENT: ______________________

DATE OF BIRTH: ______________________ SOCIAL SECURITY#: ______________________

SECONDARY INSURANCE: ______________________ ID#: ______________________

SUBSCRIBER'S NAME (if other than pt): ______________________ RELATIONSHIP TO PATIENT: ______________________

DATE OF BIRTH: ______________________ SOCIAL SECURITY#: ______________________

ASSIGNMENT AND RELEASE:

I hereby authorize my insurance benefits to be paid directly to Dr. Guthrie or Dr. Daniel. I am financially responsible for all services not covered by insurance. I also authorize the above doctors to release medical information as required by my insurance company.

SIGNATURE OF INSURED OR AUTHORIZED AGENT: ______________________

DATE: ______________________

DP Forms/Intake (11-2011)