BRETT RUFFO, M.D.

PATIENT DEMOGRAPHIC INFORMATION

PLEASE PRINT ALL INFORMATION

PATIENT NAME:	DATE OF BIRTH:	SEX ( ) M ( ) F MARITAL STATUS ( ) S ( )M		SOCIAL SECURITY #:
ADDRESS:	CITY:	STATE:	ZIP CODE:	TELEPHONE #:
MAILING ADDRESS (IF DIFFERENT):	CITY:	STATE:	ZIP CODE:	CELL PHONE #:
PHARMACY NAME AND PHONE:		NAME OF PRIMARY CARE PHYSICIAN AND PHONE:		

INSURANCE INFORMATION

PATIENTS PRIMARY INSURANCE NAME:	IDENTIFICATION #:		GROUP # (IF APPLICABLE):
POLICY HOLDERS NAME, IF OTHER THAN PATIENT:	DATE OF BIRTH:	SOCIAL SECURITY #:	RELATIONSHIP TO PATIENT:
PATIENTS SECONDARY INSURANCE:	IDENTIFICATION #:		GROUP # (IF APPLICABLE):
POLICY HOLDERS NAME, IF OTHER THAN PATIENT:	DATE OF BIRTH:	SOCIAL SECURITY #:	RELATIONSHIP TO PATIENT:

EMPLOYER INFORMATION ( ) CURRENTLY EMPLOYED ( ) RETIRED ( ) STUDENT

IF EMPLOYED, EMPLOYER NAME:	ADDRESS:	TELEPHONE #:

EMERGENCY CONTACT INFORMATION

NAME:	RELATIONSHIP:	TELEPHONE #:

IS YOUR TREATMENT RELATED TO A WORKER'S COMPENSATION OR NO FAULT CLAIM? ( ) YES ( ) NO
IF YES, PLEASE PROVIDE APPROPRIATE INFORMATION BELOW

NO FAULT INFORMATION

ACCIDENT OR INJURY DATE:		WAS THIS ACCIDENT REPORTED? ( ) YES ( ) NO	
WERE YOU A: ( ) PASSENGER ( ) DRIVER ( ) PEDESTRIAN ( ) OTHER			
INSURANCE CO.:	CLAIM #:	POLICY #:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
INSURED'S NAME:	ADJUSTER'S NAME:		TELEPHONE #:

WORKER'S COMPENSATION INFORMATION

ACCIDENT OR INJURY DATE:		WAS THIS ACCIDENT REPORTED? ( ) YES ( ) NO	
INSURANCE CO.:	WC CLAIM #:	POLICY #:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
NAME OF CARRIER CONTACT:		TELEPHONE #:	
EMPLOYER:		TELEPHONE #:	
ADDRESS:	CITY:	STATE:	ZIP CODE:

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____