MARK C. ENGASSER, M.D.P.A.

PATIENT_____
LAST *FIRST* *MIDDLE*

If patient is a child, Responsible Party_____

Home Address _____City _____State_____

Zip _____ Home Phone_____Work Phone_____

E-mail address _____

Birth date_____ Age_____ Sex M F SS #_____

Employer_____Address_____

Referring Doctor_____Primary Care Doctor_____

Marital Status: please circle Single Married Widow Divorced

Reason for your appointment today_____

Area to be examined _____ Rt____Lt____ DATE OF INJURY_____

Recent tests_____

We need your help to remain a certified Electronic Health Record (EMR) user. In order to comply with government requirements for use of a certified EMR, we are now required to request and record the race and ethnicity requirements.

Primary Language_____Race_____

Ethnicity: Please circle Not Hispanic or Latino Hispanic or Latino

PERSONAL HEALTH INSURANCE: _____

GROUP #_____ID #_____

ADDRESS_____

WORK COMP or AUTO CO_____

CLAIM #_____DATE OF INJURY_____

ADDRESS_____

CLAIM REP_____PHONE_____

Employer at time of Injury_____