

PLEASE COMPLETE THE ENTIRE FORM

Today's Date: _____

Patient Information:

Reason for Today's Visit: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone:(_____) _____ Cell Phone:(_____) _____ Work Phone:(_____) _____

Gender: Male Female (check box) E-mail: _____

Date of Birth: ____/____/____ Social Security: _____ - _____ - _____ Marital Status: Single/Married/Divorced/Widowed

Primary Care Physician: _____ Primary Care Physician Phone:(_____) _____

Employer Name: _____ Employer Phone:(_____) _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

How You Heard About Us: _____

Patient Insurance/Billing Information:

Primary Insurance:

Insurance Name: _____ Phone:(_____) _____

Policy/ID#: _____ Group#: _____

Subscriber Name: _____ Date of Birth: ____/____/____

Social Security: _____ - _____ - _____ Relationship to Patient: _____

Secondary Insurance:

Insurance Name: _____ Phone:(_____) _____

Policy/ID#: _____ Group#: _____

Subscriber Name: _____ Date of Birth: ____/____/____

Social Security: _____ - _____ - _____ Relationship to Patient: _____

ALL PATIENTS AND/OR GUARANTOR: I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay direct to Provider, the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Signature of Patient/Responsible Party

Date