



PATIENT INFORMATION

TODAY'S DATE: _____ HOME PHONE: _____
 EMAIL: _____ CELL PHONE: _____
 NAME: _____ SOCIAL SECURITY #: _____
LAST NAME FIRST NAME INITIAL
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 SEX: M F AGE: _____ BIRTH DATE: _____
 SINGLE MARRIED WIDOWED SEPARATED DIVORCED
 PATIENT EMPLOYED BY: _____ OCCUPATION: _____
 BUSINESS ADDRESS: _____ BUSINESS PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____
 IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? _____ PHONE: _____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT: _____
LAST NAME FIRST NAME INITIAL
 RELATION TO PATIENT: _____ BIRTH DATE: _____ SOCIAL SECURITY #: _____
 ADDRESS: _____ PHONE: _____
 CITY: _____ STATE: _____ ZIP: _____
 PERSONAL RESPONSIBLE EMPLOYED BY: _____ OCCUPATION: _____
 BUSINESS ADDRESS: _____ BUSINESS PHONE: _____
 INSURANCE COMPANY: _____
 CONTRACT #: _____ GROUP #: _____ SUBSCRIBER #: _____
 NAME OF OTHER DEPENDENTS COVER UNDER THIS PLAN: _____

ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? YES NO
 SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____ BIRTH DATE: _____
 ADDRESS: _____ PHONE: _____
 CITY: _____ STATE: _____ ZIP: _____
 SUBSCRIBER EMPLOYED BY: _____ BUSINESS PHONE: _____
 INSURANCE COMPANY: _____ SOCIAL SECURITY #: _____
 CONTRACT #: _____ GROUP #: _____ SUBSCRIBER #: _____
 NAME OF OTHER DEPENDENTS COVER UNDER THIS PLAN: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
NAME OF INSURANCE COMPANY(IES)
 and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for
 services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor
 to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

 RESPONSIBLE PARTY SIGNATURE

 RELATIONSHIP

 DATE

