

PATIENT INFORMATION

PRIMARY DOCTOR _____

Name _____ S.S.# _____ / _____ / _____

Birth Date: _____ / _____ / _____ Sex: Male / Female Marital Status: S ___ W ___ D ___ M ___

Street Address: _____ City: _____

State: _____ Zip: _____ Home Phone:(_____) _____ Cell Phone:(_____) _____

Employ Status: Full-time ___ Part-time ___ Not Employed ___ Self ___ Active Duty ___

Student Status: Full-time ___ Part-time ___ Not student ___

Employer or School: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: (_____) _____

Emergency Contact Person: _____ Phone (_____) _____

IF PATIENT IS A MINOR (under 18 years old), COMPLETE THE NEXT 5 LINES	
Person responsible for Payment: _____	Phone (_____) _____
Birth Date: _____ / _____ / _____ SS# _____ / _____ / _____	Relationship to Patient _____
Street Address: _____	
City, State, Zip: _____	
Employer: _____	Phone (_____) _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Ins. Co Name _____

I. D. Number _____

Group/Plan Number _____

Ins. Co. Address: _____

City, State, Zip: _____

Policy Owner Name: _____

S. S. # Of Policy Owner _____ / _____ / _____

_____ / _____ / _____

Birth date of Policy Owner: _____ / _____ / _____

_____ / _____ / _____

Relationship to Policy Owner _____

Ins. Co-Pay: \$ _____

By my signature below, I hereby request and consent to medical treatment and I authorize the release of medical information as outlined in the practice Privacy of Information Policy I have been given. I authorize payment directly to the physician or supplier for services rendered and I recognize that I am ultimately responsible for payment for services regardless of insurance coverage or non-coverage.

Authorized Signature _____ Date _____

The above information is current and accurate and I renew my above authorization _____ Date _____

The above information is current and accurate and I renew my above authorization _____ Date _____