Patient Information

Last Name ________________________________ **First Name**________________________________

Address ____ **Apt.**_______________

City ______________________________ **State** ________ **Zip** ______________

Date of Birth _____________ **Age** ______ **Sex** _____ **Social Security #** ___________________ **Marital Status** __________

Home # _____________________**Office #** ______________________ **Cell#** __________________________

Email Address _____________________________________

Emergency Contact ___________________________________ **Phone#** _______________________

Relationship to Patient ______________________

Employer's Name ___________________________________ **Occupation:** ___________________

Employer's address ______________________________**City**__________ **State** _____ **Zip Code**_______

Referred by ____

Primary Care Dr. ____________________________ **Telephone#** _______________________ **Fax#** _______________

Insurance Information

Primary Insurance

Subscriber's Name _____________________________ **Subscriber's Date of Birth** _______________

Relationship to Subscriber: ___**self** ___**child** ____**spouse** ____**other** **Subscriber's Social Security #** __________________

Insurance Company_____________________ **ID#** _______________________ **Group #** _____________________

Secondary Insurance

Subscriber's Name______________________________ **Subscriber's Date of Birth** ___________________

Relationship to subscriber ____**self** ____**child** ____**spouse** ___ **other** **Subscriber's Social Security #** ____________________

Insurance company __________________________ **ID#** ________________________ **Group #** _________________________

I authorize Payment of medical benefits directly to the physician. I further authorize the release of any information necessary to process these medical claims. I understand that I am financially responsible for ALL deductibles, co-payments, referrals, non-covered services that may apply as directed by my insurance plan. For questions about your coverage, please contact your insurance company directly. (It is the policy of this office to bill for any missed appointments unless given at least 24hrs notice. I understand that unless I give such notice, I will be charged a fee $25.00)

Signature of Patient ____ **Date** _____________________