

PATIENT INFORMATION

PATIENT'S FULL NAME _____ M / F (CIRCLE ONE)
STREET ADDRESS _____
CITY, STATE AND ZIP _____
PHONE # (home) _____ (work) _____ (cell) _____
EMPLOYER _____
DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____
MARITAL STATUS _____ REFERRED BY: _____
RESPONSIBLE PARTY (IF PT IS MINOR) _____
ADDRESS (IF DIFFERENT FROM PT) _____

INSURANCE INFORMATION

(PLEASE PRESENT YOUR INSURANCE CARD AND STATE/PICTURE ID TO THE RECEPTIONIST)

PRIMARY INSURANCE NAME

CARDHOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____
CARDHOLDER'S BIRTHDATE _____ CARDHOLDER'S SS# _____
CARDHOLDER'S ADDRESS (IF DIFFERENT FROM PT) _____
CARDHOLDER'S EMPLOYER _____ PHONE _____
IN THIS POLICY AN HMO? _____ IS THIS POLICY A PPO? _____

SECONDARY INSURANCE NAME

CARDHOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____
CARDHOLDER'S BIRTHDATE _____ CARDHOLDER'S SS# _____
CARDHOLDER'S ADDRESS (IF DIFFERENT FROM PT) _____
CARDHOLDER'S EMPLOYER _____ PHONE _____
IN THIS POLICY AN HMO? _____ IS THIS POLICY A PPO? _____

I UNDERSTAND THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT. I HAVE READ ALL OF THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE. I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR MEDICAL SERVICES PERFORMED FOR ME. I ALSO REQUEST PAYMENT BE SENT TO THE PROVIDER OF SERVICES.

SIGNATURE _____ DATE _____