Patient Information
Please Print

Date: _____ Home Phone # _____
Cell. Phone # _____
E-MAIL address _____

Name _____
Address _____
City _____ State _____ Zip Code _____
Birthday _____ Age _____ Social Security # _____
Sex: Female Male Marital Status: Single Married Divorced Widowed

EMERGENCY CONTACT
Name _____ Phone # _____
Address _____

EMPLOYER INFORMATION
Employer _____
Occupation _____ Phone # _____

INSURANCE INFORMATION
Name of Primary Insurance Company _____
Name of Policy Holder _____ D.O.B _____
Policy # _____ Group # _____
Secondary Insurance Company _____
Policy # _____ Group # _____

How were you referred to our practice? Physician _____
Friend/Relative (if so, name) _____
Yellow Pages Newspaper Other: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with the issuer). IN ORDER TO HELP CONTROL THE COST OF BILLING, **WE REQUEST PAYMENT BE MADE FOR ALL OFFICE SERVICES AT THE TIME OF YOUR VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO SERVICES BEING RENDERED.**
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial Insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature _____

Date _____