PATIENT INFORMATION *(please print)* **Date: ___/___/_____**

Name (Last, First, MI)____

Mailing Address (Street, Apt., City, State, Zip Code)_______________________________________

____Email____________________

Home Phone ____________________ Work Phone___________________ Cell_________________________

SS#_______________________Date of Birth _____/_____/______ Age____ Sex ____ Marital Status__________

Employer ____ Occupation _________________________

OTHER ADDRESS or PARENT OR RESPONSIBLE PARTY (*if different from patient*)

Name (Last, First, MI)

____

Mailing Address (Street, Apt., City, State, Zip Code)_______________________________________

____Email__________________________

Home Phone ____________________ Work Phone_____________________ Cell_________________________

SS#____________________ Date of Birth _____/_____/________ Sex _______ Relationship:_______________

Employer ____ Occupation _________________________

INSURANCE INFORMATION *(please present insurance card at time of check-on)*

Primary Insurance Name ___________________________

Ins. Address______________________________________

Name of Insured___________________________________

Insured's ID# _____________________________________

Group #____

Employer Name ___________________________________

Employer Address _________________________________

Employer Phone ___________________________________

Relationship of patient to insured ___________________

Secondary Insurance Name __________________________

Ins. Address______________________________________

Name of Insured___________________________________

Insured's ID# _____________________________________

Group #____

Employer Name ___________________________________

Employer Address _________________________________

Employer Phone ___________________________________

Relationship of patient to insured ___________________

Other family member that are patients ____

Pharmacy of choice ____Phone ____________________

In case of an emergency, who should be notified ? ______________________________Phone __________________

Referred by: ____

I authorize the release of medical information to my referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

By signing below, I state that the above information is true and correct. I will inform this office of any changes that are made as they occur.

Patient or Responsible Party Signature:

____Date _____/_____/_________