

Patient Information

Name: _____
 First _____ Mid _____ Last _____

Address: _____
 Street or PO Box _____ City _____ State _____ Zip _____

Home Phone: () _____ **Mobile:** () _____
 Please circle preferred telephone number that you would prefer us to call

Date of Birth: ____ / ____ / ____ **Sex:** M F **Marital Status:** _____ **Race:** _____ **Ethnicity:** Hispanic Non-Hispanic

Soc Sec #: _____ - _____ - _____ **Language:** _____ **Email:** _____
 (E-Mail is for educational purposes only.)

Referring: _____
 Physician Name _____ Phone # _____

Employer: _____
 Company Name _____ Address _____ City, State, Zip _____ Phone _____

Emergency: _____
 Contact Person _____ Relationship _____ Phone _____

Spouse / Parent and/or Responsible Party Information

Primary Insurance Information

Carrier Name: _____ **Carrier Phone #:** _____
Policy #: _____ **Group #:** _____

Claims Address: _____

Subscriber's Name: _____ **Relationship to Patient:** _____
Subscriber's Employer: _____ **Subscriber Birth Date:** _____

Employer Address: _____ **Emp Phone #:** _____ **Subs. SS#:** _____

Secondary Insurance Information

Carrier Name: _____ **Carrier Phone #:** _____
Policy #: _____ **Group #:** _____

Claims Address: _____

Subscriber's Name: _____ **Relationship to Patient:** _____
Subscriber's Employer: _____ **Subscriber Birth Date:** _____

Employer Address: _____ **Emp Phone #:** _____ **Subs. SS#:** _____

If **MEDICARE** is listed as the *Secondary Insurance*, please check the reason:

- Working age beneficiary / spouse Disabled Beneficiary under age 64 VA (Veteran's Administration)
 End State Renal Disease Worker's Compensation Other:

Authorization to Release Information and Assignment of Benefits

I hereby authorize the release of any information necessary to process my insurance claims. I hereby authorize payment directly to the Physician or representative for any professional services rendered to my dependent or me. I further understand that I am financially responsible for any charges not paid by my insurance company, unless my insurance plan is not one that contracts directly with the Physician and they determine that I am not responsible. Regulations pertaining to medical assignment of benefits apply. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor listed above. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services.

Patient's Signature: _____ **Date:** _____
Guarantor's Signature: _____ **Date:** _____
 (If other than Patient)