PATIENT INFORMATION

NAME:_____ HOME PHONE:_____

STREET ADDRESS:_____ OTHER PHONE:_____

CITY:_____ DATE OF BIRTH:_____AGE:_____

STATE:_____ZIP:_____ SSN:_____

Email address_____ EMPLOYER:_____

SEX: ____M _____F Marital Status: _____

EMP ADDRESS:_____

REFERRING PHYSICIAN:_____

EMP PHONE #:_____

PRIMARY CARE PHYSICIAN:_____

RESPONSIBLE PARTY IF DIFFERENT FROM PATIENT

NAME:_____ HOME PHONE:_____

ADDRESS:_____ WORK PHONE:_____

CITY:_____ DATE OF BIRTH:_____

STATE:_____ZIP CODE:_____ SSN:_____

RELATION TO PATIENT:_____

EMPLOYER:_____ ADDRESS:_____

PERSON TO CONTACT RELATION

IN CASE OF EMERGENCY:_____ PHONE:_____TO PATIENT:_____

INSURANCE INFORMATION Is this claim Workers Comp_____or an accident _____

Plan Name:_____ Are you the primary cardholder? ____Yes ____No

If not, who is the primary cardholder:_____

Cardholders date of birth:_____ Relation to patient:_____

Please give insurance card(s) to the receptionist to copy. If you do not have them with you today, you will be responsible for charges related to today's visit including outpatient testing and/or surgery unless we get a copy (front and back) at least a week before any scheduled test/procedure.

Pharmacy Information

Address_____

Pharmacy Name_____ Phone_____

I hereby authorize the release of any medical information necessary to process my insurance and to act as my agent to appeal unpaid or denied claims.

Date:_____ Signature:_____

I hereby authorize payment directly to the provider of service and I understand that I am financially responsible for my copays, coinsurance and deductibles as well as any services not deemed medically necessary by my insurance company.

Date:_____ Signature:_____