

PATIENT INFORMATION CIRCLE DATE OF BIRTH ____/____/____

NAME: _____ MALE FEMALE SOCIAL SECURITY ____-____-____
LAST FIRST MI

ADDRESS: _____ HOME PHONE (____) _____
CITY STATE ZIP WORK PHONE (____) _____

PLEASE CIRCLE: MARITAL STATUS: SINGLE MARRIED DIVORCED OTHER

REFERRED BY: FRIEND YELLOW PAGES REFERRAL PROGRAM WALK IN OTHER PHYSICIAN _____

EMERGENCY CONTACT (LIVING AT ANOTHER LOCATION)

NAME: _____ RELATIONSHIP: _____
DAY PHONE: (____) _____ NIGHT PHONE: (____) _____

GUARANTOR INFORMATION (WHO IS RESPONSIBLE FOR THIS ACCOUNT - USUALLY, THE PERSON COMPLETEING THE FORM)

NAME: _____ SOCIAL SECURITY ____-____-____ DOB ____/____/____
LAST FIRST MI

ADDRESS: _____ HOME PHONE (____) _____
CITY STATE ZIP WORK PHONE (____) _____

RELATIONSHIP TO PATIENT: SELF FATHER MOTHER GRANDPARENT OTHER _____

EMPLOYER _____ WORK PHONE (____) _____

ADDRESS: _____ EXTENSION # (____) _____
CITY STATE ZIP DRIVERS LICENSE # _____

INSURANCE INFORMATION: Our facility will only file insurance for certain health plans. Please verify whether or not your plan is eligible upon return of this form.

PRIMARY INSURANCE _____ PHONE (____) _____

ADDRESS: _____ POLICY # _____
CITY STATE ZIP GROUP # _____

NAME OF INSURED _____ INSURED DATE OF BIRTH ____/____/____

INSURED SOCIAL SECURITY ____-____-____ EMPLOYER _____

SECONDARY INSURANCE _____ POLICY # _____

ADDRESS: _____ GROUP # _____
CITY STATE ZIP PHONE # _____

NAME OF INSURED _____

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE PATIENT INDICATED ON THIS FORM. AUTHORIZATION IS HEREBY GRANTED TO RELEASE INFORMATION AS MAY BE NECESSARY TO PROCESS AND COMPLETE MY CLAIM. AUTHORIZATION IS GRANTED TO RELEASE MEDICAL INFORMATION TO ANY PHYSICIANS OR ENTITIES I MAY BE REFERRED TO.

SIGNATURE DATE

I UNDERSTAND AND I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AT THIS FACILITY. I UNDERSTAND THE POLICY OF THIS FACILITY IS TO PAY FOR SERVICES AT THE TIME OF SERVICE. IN THE EVENT MY HEALTH INSURANCE IS FILED BY THIS FACILITY, I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE PAID DIRECTLY TO THE ATTENDING PHYSICIAN FOR SERVICES RENDERED.

SIGNATURE DATE