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PATIENT INFORMATION

PLEASE PRINT

NAME _____ SEX ☐ MALE ☐ FEMALE
LAST NAME FIRST NAME MI

BIRTHDATE _____ SOC. SEC. NUMBER _____ EMAIL _____

ADDRESS _____ APT. NUMBER _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ BUSINESS PHONE _____

IS IT OKAY TO LEAVE A MESSAGE? ☐ YES ☐ NO

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ MINOR (UNDER 18YRS)

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____ PHONE _____

WHO SHOULD WE THANK FOR REFERRING YOU? _____

PRIMARY PHYSICIAN NAME _____ PHONE _____

PRIMARY INSURANCE

POLICY HOLDER NAME _____

RELATIONSHIP TO PATIENT _____ BIRTHDATE _____ SOC. SEC. NUMBER _____

INSURANCE COMPANY NAME _____ POLICY EFFECTIVE DATE _____

SUBSCRIBER NUMBER _____ GROUP NUMBER _____

ADDITIONAL INSURANCE (IF APPLICABLE)

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐YES ☐ NO

POLICY HOLDER NAME _____ SEX ☐ MALE ☐ FEMALE

RELATIONSHIP TO PATIENT _____ BIRTHDATE _____ SOC. SEC. NUMBER _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY NAME _____ POLICY EFFECTIVE DATE _____

SUBSCRIBER NUMBER _____ GROUP NUMBER _____

AUTHORIZATION AND RELEASE

I AUTHORIZE THIS RELEASE OF ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYERS AND/OR OTHER HEALTH PRACTIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DOCTOR INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I AGREE TO BE RESPONSIBLE FOR ANY NON-COVERED FEES, COPAYMENTS, COINSURANCE, AND DEDUCTIBLES.

SIGNATURE OF PATIENT _____ DATE _____