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Patient Name: ______________________________ Date of Birth: ____ / _____ / _______ Gender: Male / Female
Social Security Number: ___________________________ Marital Status: [ ] Single [ ] Married [ ] Other
Ethnicity: [ ] Non Hispanic *(Caucasian / African American / Other)* [ ] Hispanic
Street Address: _______________________________ City: ________________________ State: _______ ZIP: _________
Home Phone: __________________________ Cell Phone: _____________________ Work Phone: __________________
Email Address: __________________________
Emergency Contact Name: __________________________ Emergency Phone: ___________________________________
Employer Name: _______________________ Employer's Address City / State / Zip: _______________________________

Referring Doctor Name: _________________ Referring Doctor Address City / State / Zip: __________________________
Primary Care Physician: _________________ Primary Care Address City / State / Zip: ______________________________

Primary Insurance Company: ___________________________
Policy Holder Name: __________________________________
Policy Holder Social Security Number: ____________________
Gender: Male / Female
Relation to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other
Policy Holder's DOB: ____________
Effective Date: _________________________
Do you have a Co-Pay: [ ] YES [ ] NO Amount: $ _________
Referral Required: [ ] YES [ ] NO

Secondary Insurance Company: ___________________
Policy Holder Name: ____________________________
Policy Holder SSN: ______________________________
Gender: Male / Female
Relation to Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other
Policy Holder's DOB: ____________
Effective Date: ___________________________
Do you have a Co-Pay: [ ] YES [ ] NO Amount: $_____
Referral Required: [ ] YES [ ] NO

Responsible Party Information: *Please complete if the individual responsible for payment is not the Patient or the Policy Holder*
Responsible Party's Name: ___________________________ Responsible Party's SSN: ____________________
Relationship to Responsible Party: [ ] Self [ ] Spouse [ ] Child [ ] Other
Responsible Party's Address: ____

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is as a courtesy that the doctor accepts my insurance for payment and that if for any reason they do not pay my bill, I AM RESPONSIBLE.

[ ] I Have Received or Reviewed the Confidentiality Agreement (HIPAA) and agree to comply with all its terms.

Today's Date: __________________ **Patient's Signature (or parents if under 18 y/o):** _________________________________