PATIENT INFORMATION

Name _____ Date _____
Last Name First Name Middle Initial

Address _____ Home Phone (_____) _____

City _____ State _____ Zip _____ Cell Phone (_____) _____

Sex ☐ M ☐ F Age _____ Birthdate _____ Soc. Sec. # _____

Circle: Married Widowed Single Minor Separated Divorced Partnered Occupation _____

Referring Physician _____ Email _____

How did you hear about our practice? _____

In case of emergency who should be notified? _____ Phone (_____) _____

PRIMARY INSURANCE

Subscriber Name _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Insurance Company _____

Group # _____ Subscriber # _____

SECONDARY INSURANCE

Subscriber Name _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Insurance Company _____

Group # _____ Subscriber # _____

ASSIGNMENT OF BENEFITS • FINANCIAL AGREEMENT

If under age 18, Responsible Party Name _____

I hereby give lifetime authorization for payment of insurance benefits to be made directly to _____, and any assisting physicians, for services rendered I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____
Signature of Patient, Parent, Guardian or Responsible Party Date

_____ _____
Please print name of Patient, Parent, Guardian or Responsible Party Relationship to Patient