

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