PATIENT INFORMATION

PLEASE FILL IN EVERY BLANK

Name (Last, First, Middle Initial)				Title		
Street Address	Apt/Suite	City		State	Zip	
Home Phone	Work Phone	Emergency Phone		Emergency Contact		
( )	( ) ext.	( ) ext.				
SS No.	Birth Date (mm/dd/yy)	Age	Gender	Marital Status	Race	Smoker?
- -	/ /		**M F**	**M S W D**		**Y N**
Family Dr.			Referral Dr.			
Employer/School Name and Complete Address						

SPOUSE IF MARRIED or PARENT IF UNDER AGE 18

Relationship to Patient			Name (Last, First, Middle Initial)		
Street Address	Apt/Suite	City		State	Zip
Home Phone	Work Phone		SS No.		
( )	( ) ext.		- -		
Birth Date (mm/dd/yy)	Gender				
/ /	**M F**				
Employer Name and Business					

INSURANCE PLAN INFORMATION

Primary Plan Name				
Street Address	Apt/Suite	City	State	Zip
Policy No.	Group No.	Effective Date (mm/dd/yy)	Expiration Date (mm/dd/yy)	
		/ /	/ /	
Policy Owner/Relationship		SS No.	Birth Date (mm/dd/yy)	
		- -	/ /	
Secondary Plan Name		Policy Owner/Relationship		
Street Address	Apt/Suite	City	State	Zip
Policy No.	Group No.	Effective Date (mm/dd/yy)	Expiration Date (mm/dd/yy)	
		/ /	/ /	

PLEASE READ THE FOLLOWING PARAGRAPH AND SIGN AT THE BOTTOM

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries carriers, or my private insurance carrier, any information needed for this or a related insurance claim. I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize the doctor to bill all services and allow my insurance carrier to issue undemnity payments directly to the physician. I understand that any services not covered by insurance are the responsibility of the guarantor.

Signature Date Signature of Parent or Guardian if patient is a minor