PATIENT INFORMATION *(Please use legal name)* **PLEASE PRINT CLEAR**

Name of Patient: ____Birth Date:____/____/______
Last First MI

Age: __________ Sex: ◯ Male ◯ Female Social Security #:______/____/_______

Home Address: ____
(City) (State) (Zip)

Mailing Address: ____
(City) (State) (Zip)

Cell Phone #: (_____)_______________ Home Phone #: (_____)____________

Employer: __________________________ Work Phone#:(_____)_____________ Ext. _________

Emergency Contact: _______________________________________Day Time Phone # (_____)____________
(Name) (Emergency Contact)

Referring Physician: ____________________________________ Phone #: ______________

Custodial Parent if Patient is Child: ________________________Birth Date:____/____/______
(Name)

Address: _____________________________________City: _________________________ State: _____ Zip:____________

Home #: (____) _______________ Work Phone #: (____) _______________ Ext: ___________

Employer: ____

Insurance Information: We will need a copy of the insurance card in order to file a claim.

Primary Insurance Coverage: ____
Insured Name: __________________________ Birth Date: ____/____/____ SSN#: ______________
Relationship to Patient: ________________________________ Policy #: ______________________
Group #: ______________________________Primary Insured Employer: ______________________

Secondary Insurance Coverage: ____
Insured Name: __________________________ Birth Date: ____/____/____ SSN#: ______________
Relationship to Patient: ________________________________ Policy #: ______________________
Group #: ______________________________Primary Insured Employer: ______________________

Third Insurance Coverage:____
Insured Name: __________________________ Birth Date: ____/____/____ SSN#: ______________
Relationship to Patient: ________________________________ Policy #: ______________________
Group #: ______________________________Primary Insured Employer: ______________________

Family Members:

Name: ___________________________________ DOB: ________Name: ____DOB: ________
Name: ___________________________________ DOB: ________Name: ____DOB: ________

Patient/Custodial parent Signature:

I hereby apply for treatment by the physicians of this practice and or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to this practice. I understand that payment is due at the time of service and that I am financially responsible for all charges, whether or not paid by insurance. I have been given a copy of the HIPPA Privacy Statement.

Signature: ____ Date: ____/____/____