PATIENT INFORMATION

DATE________________________________ SOCIAL SECURITY #________________________________

NAME____

ADDRESS____

CITY________________________________ STATE____________ ZIP____________________

HOME PHONE.________________________________ CELL PHONE.________________________________

SEX M F AGE____________ BIRTIIDATE____________________ SINGLE MARRIED WIDOWED DIVORCED

PATIENT EMPLOYER/ SCHOOL________________________________ OCCUPATION____________________

EMPLOYER/SCHOOL ADDRESS________________________________ PHONE____________________

WHO MAY WE THANK FOR REFERRING YOU?____

EMERGENCY CONTACT NAME____________________ RELATION______________ PHONE______________

INSURANCE INFORMATION PRIMARY

INSURANCE

PERSON RESPONIBLE FOR ACCOUNT________________________________ RELATION TO PT______________

INSURANCE COMPANY____

CONTRACT/ID NUMBER________________________________ GROUP NUMBER____________________

SECONDARY INSURANCE (IFAPPLICABLE)

SUBSCRIBERNAME________________________________ RELATION TO PATIENT____________________

INSURANCE COMPANY____

CONTRACT/ IDNUMBER________________________________ GROUP Number ____________________

I CERTIFY THAT I AND/OR MY DEPENDENT(S) HAVE INSURANCE COVERAGE WITH____________________ AND ASSIGN DIRECTLY TO DR. ______________________ ALL INSURANCE BENEFITS. IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR ALLCHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE ABOVED-NAMED DOCTOR(S) MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE- NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

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SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

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PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT