



Welcome to our office. Please take a moment to complete this form. Please present insurance card(s) and photo ID to the receptionist so copies can be made. **Thank you.**

PATIENT INFORMATION: (Please Print) Date ____/____/____

SS# _____ Marital Status: M S W D

Name _____
FIRST M.I. LAST

Mailing Address _____
NUMBER and STREET CITY STATE ZIP

Sex _____ Age _____ Date of Birth ____/____/____

Home (_____) _____ Cell (_____) _____ Work (_____) _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Company _____

Name of Insured _____

Date of Birth ____/____/____

SS# _____

Insured ID# _____

Group # _____

Co-payment \$ _____

Employer Name _____

Employer Address _____

Employer Phone (_____) _____

Relationship to Patient _____

Insurance Company _____

Name of Insured _____

Date of Birth ____/____/____

SS# _____

Insured ID# _____

Group # _____

Co-payment \$ _____

Employer Name _____

Employer Address _____

Employer Phone (_____) _____

Relationship to Patient _____

★ **Can we call you with results or to answer your questions at your:**
(please list all that apply)

Cell Phone Number (_____) _____

Home Phone Number (_____) _____

Work Phone Number (_____) _____

Pharmacy of choice _____ Phone (_____) _____

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

Name & Address of Referring Physician (if known) _____

Primary Care Physician _____

I authorize the release of medical information to my primary care or referring physician, to consult if needed and as necessary to process insurance claims, insurance application, and prescriptions. I also authorize payment of medical benefit to the physician. **I understand that I am financially responsible for the services rendered, regardless of insurance coverage. If my insurance company requires referrals or prior authorization, it is my responsibility to obtain them prior to each service. If this is not obtained, I will be responsible for payment of my medical bill. Finally, I agree to pay for a regular doctor visit in the event of missing my scheduled appointment without calling to cancel or to reschedule. In the event that your account must be turned over to collections, a \$30.00 collection fee will be added to your account. There will be a \$30.00 fee on returned checks. Your signature below signifies your understanding and willingness to comply with these policies.**

Patient or Responsible Party **X** _____ Date ____/____/____
SIGNATURE