

PLEASE PRINT

MR.
MRS.
MISS

PATIENT LAST NAME		FIRST NAME	MIDDLE	
SOCIAL SECURITY #	DATE OF BIRTH	AGE	DRIVERS LICENSE #	
ADDRESS	APT #	CITY	STATE	ZIP CODE
() HOME PHONE	SEX	MARITAL STATUS	REFERRED BY	
EMPLOYED BY	EMPLOYERS ADDRESS	OCCUPATION	BUS. PHONE	
SPOUSE'S NAME	EMPLOYED BY	EMPLOYERS ADDRESS	BUS. PHONE	
NEAREST RELATIVE NOT LIVING WITH YOU		RELATIONSHIP	PHONE #	

MEDICAL INSURANCE INFORMATION

INSURANCE HOLDERS DATE OF BIRTH				INSURANCE HOLDERS SOCIAL SECURITY #		
COMPANY	SUBSCRIBER #	POLICY #	COMPANY	SUBSCRIBER #	POLICY #	
MEDICAID NUMBER			MEDICARE NUMBER			

PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE BILL

NAME	ADDRESS	CITY	STATE	ZIP CODE	
HOME PHONE	RELATIONSHIP TO PATIENT			OCCUPATION	
EMPLOYER	ADDRESS	CITY	STATE	ZIP	BUS. PHONE

RELEASE AND ASSIGNMENT

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE ANY INFORMATION NEEDED TO PROCESS MY INSURANCE CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN.

X

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

HAS ANYONE IN YOUR IMMEDIATE FAMILY BEEN SEEN IN OUR OFFICE? YES NO

METHOD OF PAYMENT () CASH () CHECK () CHARGE

TODAY'S DATE _____