

PATIENT NAME (First Name, Middle Initial, Last Name)	PATIENT ID (Office Use Only) 47775	FIRST PHONE (HOME)	SECOND PHONE (WORK)	THIRD PHONE (MOBILE)
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX (M or F) <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other
CITY, STATE, ZIP	AGE	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER	OCCUPATION	PATIENT E-MAIL ADDRESS		
REFERRING DOCTOR NAME & ADDRESS				
PRIMARY CARE DOCTOR NAME & ADDRESS				

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	SEX (M or F)	PATIENT'S RELATION TO RES
CITY, STATE, ZIP	OCCUPATION	RESP PARTY ID (Office Use Only)
EMPLOYER		

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)
 Patient (same as above) Responsible Party (same as above) Other (complete below)

INSURANCE COMPANY NAME	COPY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP			
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH			
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED	
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER	INSURED'S OCCUPATION	

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)
 Patient (same as above) Responsible Party (same as above) Other (complete below)

INSURANCE COMPANY NAME	INSURED'S NAME (First Name, Middle Initial, Last Name)			
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP			
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH			
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED	
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER	INSURED'S OCCUPATION	

Authorization and Acknowledgement

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed. I understand I will be responsible for any collection fees if this account is delinquent.

Signature of Patient / Parent / Guardian _____ Printed Name _____ Date _____

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian / Insured _____ Printed Name _____ Date _____