PATIENT INFORMATION

Patient Name _____
(last) (first) (middle)
Address _____ (city)_____ (state) _____ (zip) _____

Date of birth _____(mm/dd/yyyy) SSN _____ Sex: Male/Female

Home phone ( ) _____ Cell phone ( ) _____ Email _____

Employer _____ Work Phone _____

Business Address _____ __ (city)_____ (state) _____ (zip) _____

Spouse's name _____ Employer _____ Work Phone _____

Name of Primary Care Provider (PCP) _____Tel _____

Address of clinic _____ Fax _____

Referring Person (if not PCP) _____ Tel _____

Address _____ Fax_____

Emergency Contact Information

Name of friend/or nearest relative not living with you _____ Phone _____

Address _____ Relationship to you:_____

Insurance Information

Name of insured _____ Relationship to patient _____
(last) (first) (middle)
Address _____ Contact phone _____

SSN _____ Sex: Male/Female Date of birth _____(mm/dd/yy)

Name of employer _____ Work phone _____

Primary Insurance Company _____ ID# _____ Group # _____

Address _____city _____ state _____ zip _____

Secondary Insurance Company _____ ID# _____ Group # _____

Address _____city _____ state _____ zip _____

I authorized release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand I am responsible for payment of all services rendered including payment of expenses not paid by my insurance.

_____ _____
Signature of Patient Date