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Please PRINT clearly with BLACK INK

Date of Appointment: _____ Referring Physician or Primary Care Physician _____
Patient's Legal Name: _____ Name pt goes by: _____
Address: _____ Email Address: _____
City : _____ State : _____ Zip : _____
Home #: (____) _____ Work#: (____) _____ Mobile #: (____) _____
Date of Birth : ____/____/____ Age : _____ Sex: _____ SS#: _____ - _____ - _____
Marital Status: _____ Name of Spouse: _____ # of Children: _____
Patient's Occupation: _____ Patient's Employer : _____

Emergency

Contact : _____ Relationship: _____ Phone#: (____) _____
INSURANCE #1 POLICY HOLDER Self Spouse Parent Other
Insurance Policyholder's Name (If not patient) : _____
Relationship to Patient: _____ Date of Birth: ____/____/____ SS#: ____/____/____
Employer: _____
Address (If different from above): _____

City: _____ State : _____ Zip: _____ Contact Ph#: _____
INSURANCE #2 POLICY HOLDER Self Spouse Parent Other
Insurance Policyholder's Name (If not patient) : _____
Relationship to Patient: _____ Date of Birth: ____/____/____ SS#: ____/____/____
Employer: _____
Address (If different from above): _____
City: _____ State : _____ Zip: _____ Contact Ph#: _____

Please read and sign below: I understand that regardless of my insurance coverage, I am financially responsible for all medical services received.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments, co-shares and deductibles will be collected. It is the patient's responsibility to notify this office if your insurance plan(s) require prior authorization before services are rendered. **If the patient is a minor form must be signed by a Legal Guardian or Responsible Party.**

IF PRIOR AUTHORIZATION IS REQUIRED AND NOT OBTAINED, YOU ARE FULLY RESPONSIBLE FOR ALL CHARGES INCURRED.

Patient / Responsible Party Signature _____ Date _____