PLEASE PRINT

Date:_____/_____/_____ Home Phone: (_____)_____-_____

PATIENT INFORMATION

Name:_____Social Security:_____

Address: _____Cell Phone: (_____)_____-_____

City:_____ State:_____Zip Code:_____

Sex: M [ ] F [ ] Age:_____ Birth Date: _____/_____/_____ Race: _____

Ethnicity:_____ Preferred Language:_____ Blind: [ ] Deaf: [ ]

☐ Married ☐ Widowed ☐ Single ☐ Divorced

☐ Minor ☐ Separated ☐ Partnered for _____ years

Patient Employer/School: _____ Occupation:_____

Employer/School Phone: (_____)_____-_____ E-mail: _____

Whom may we thank for referring you?:_____

Emergency Contact:_____Phone:(_____)_____-_____

PRIMARY INSURANCE

Person Responsible for Account:_____Relation to Patient:_____

Birth Date:_____/_____/_____ Social Security #:_____

Address:_____Phone: (_____)_____-_____

Person Responsible Employed by:_____ Occupation:_____

Business Address:_____Business Phone: (_____)_____-_____

Insurance Company:_____Phone: (_____)_____-_____

Member ID:_____Group:_____Subscriber:_____

Names of other dependents covered under this plan:_____

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? Yes [ ] No [ ]

Person Responsible for Account:_____Relation to Patient:_____

Birth Date:_____/_____/_____Social Security #:_____

Address:_____Phone: (_____)_____-_____

Person Responsible Employed by:_____ Occupation:_____

Insurance Company:_____Phone: (_____)_____-_____

Member ID:_____Group:_____Subscriber:_____

Names of other dependents covered under this plan:_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____

Name of Insurance Company(ies)

and assign directly to Dr._____. All insurance benefits, if any, otherwise will be payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient