PATIENT INFORMATION

Patient's Name: _____
LAST FIRST MIDDLE INT

Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____ Social Security#: _____ Marital Status: _____ Sex: _____ Birth Date: _____ Age: ____

Work Phone: _____ Email Address _____ Employer's Name: _____

Cell Phone: _____ Employer's Address: _____

Primary Care Physician including phone #: _____

Other Physicians you see including phone #'s: _____

Spouse or Person to contact in an emergency: _____ Home Phone: _____

Address: _____

Relationship to patient: _____ Employer: _____ Work Phone: _____

Person Responsible For Bill: _____ Relationship to Pt: _____

Address: _____
Street City State Zip Code

PLEASE CLIP YOUR INSURANCE CARD(S) HERE. THEY WILL BE RETURNED TO YOU AS YOU LEAVE.

Social security # of policy holder (#1 Policy) _____ (#2 Policy) _____

Birth date of policy holder (#1 Policy) _____ (#2 Policy) _____

IF NO INSURANCE CARD OR NO INSURANCE, HOW WILL YOU PAY? CHECK____ CASH____ BANKCARD____

ASSIGNMENT OF BENEFITS

I authorize the payment of medical, surgical and/or major medical benefits directly to the designated physician.
I also authorize the release of any medical information necessary to process an insurance claim.

Signature of Insured/Patient Date