Patient Information

Last Name _____ **First Name** _____ **M.I.** _____

Street Address _____ Apt. # _____

City _____ State _____ Zipcode _____

Employer _____ Business Phone _____ Home Phone _____

Date of Birth _____ Social Security _____ Sex _____

Cell Phone _____ Responsible party for payment: Self____Spouse____Parent____Other____

Emergency Contact _____ _____
Name and Relationship Phone Number

Address of Emergency Contact _____

Referring Doctor _____

Primary Insurance Holder (if different from patient)

Last Name _____ **First Name** _____ **M.I.** _____

Relationship to patient: Spouse _____ Parent _____ Other _____

Street Address _____ Apt. # _____

City _____ State _____ Zipcode _____

Home Phone _____ Business Phone _____ Employer _____

Date of Birth _____ Social Security _____ Sex _____

If there is a secondary insurance, please complete the following:

Last Name _____ **First Name** _____ **M.I.** _____

Relationship to patient: Spouse _____ Parent _____ Other _____

Street Address _____ Apt. # _____

City _____ State _____ Zipcode _____

Home Phone _____ Business Phone _____ Employer _____

Date of Birth _____ Social Security _____ Sex _____

I accept financial responsibility for any balance due (co-insurance, deductible and insured responsibility) after my insurance has paid. I further authorize the release of pertinent medical information to my insurance company in order to facilitate the payment of claims. I accept full responsibility for following up with recommended tests and/or procedures and calling the doctor to obtain the results.

_____ Patient or Guardian Signature Date _____

(rev 05/03)