Patient Information

Name: ____ DOB: _________________

Previous Name: _______________________________ Marital Status: ____________________________

Gender: __________ Social Security #: ____________________ Primary Phone #: ___________________

Mailing Address: ____

City: ___________________________________ State: ________________ Zip: __________________

Primary Care Provider: ____

Occupation: _______________ Employer: ________________________ Employer Phone #: __________

Spouse/Parent Information

Name: ____DOB: __________________

Gender: __________ Social Security #: ____________________ Primary Phone #: ___________________

Mailing Address: ____

City: ___________________________________ State: ________________ Zip: __________________

Relationship to Patient: _________________________ Occupation: ______________________________

Spouse/Parent Employer: ____________________________ Employer Phone #: ____________________

Insurance Information

(Please provide insurance card at check-in)

Insurance Company: _______________________________ ID #: _______________________________

Group #: ______________________________ Insurance Phone #:______________________________

In Case of Emergency

Name: ___________________________ Relationship: _________________ Phone: ________________

Assignment of Benefits and Release of Information

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that:

- I am financially responsible for all charges whether or not paid by my insurance
- I understand that should I default on payment of my account and collection agency services are required, all costs of collections including attorney fees will be added to the balance of my account.

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Patient Signature **Date**