PATIENT INFORMATION

Name ______________________________ Date ______________
Last Name First Name Middle Initial

Address ______________________________ Home Phone (______) ______________

City ______________ State ______ Zip ______ Cell Phone (______) ______________

Sex ☐ M ☐ F Age ______ Birthdate ______________ Soc. Sec. # ______________

Circle: Married Widowed Single Minor Separated Divorced Partnered Occupation ______________

Referring Physician ______________________ Email ______________________

How did you hear about our practice? ______________________________

In case of emergency who should be notified? ______________________ Phone (______) ______________

PRIMARY INSURANCE

Subscriber Name ______________________________
Last Name First Name Middle Initial

Relation to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address (If different from patient's) ______________________ Phone (_____) ______________

City ______________________ State ______ Zip ______

Insurance Company ______________________________

Group # ______________ Subscriber # ______________

SECONDARY INSURANCE

Subscriber Name ______________________________
Last Name First Name Middle Initial

Relation to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address (If different from patient's) ______________________ Phone (_____) ______________

City ______________________ State ______ Zip ______

Insurance Company ______________________________

Group # ______________ Subscriber # ______________

ASSIGNMENT OF BENEFITS • FINANCIAL AGREEMENT

If under age 18, Responsible Party Name ______________________________

I hereby give lifetime authorization for payment of insurance benefits to be made directly to ______________________, and any assisting physicians, for services rendered I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

______________________________ ______________
Signature of Patient, Parent, Guardian or Responsible Party Date

______________________________ ______________
Please print name of Patient, Parent, Guardian or Responsible Party Relationship to Patient