

PLEASE FILL OUT BOTH SIDES

Date _____

Marital Status (x one)

S__ M__ Sep. __ D__ W__

This section refers to **PATIENT ONLY**

This section refers to **SPOUSE or DEPENDENT or SIGNIFICANT OTHER**

NAME _____

NAME _____

BIRTHDATE ___/___/___ SS# ___/___/___

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

SEX _____ AGE _____

CELL PHONE () _____

HOME PHONE () _____

HOME PHONE () _____

CELL PHONE () _____

WORK PHONE () _____

WORK PHONE () _____

BIRTHDATE ___/___/___ SS# ___/___/___

EMPLOYER _____

RELATIONSHIP TO PATIENT _____

ADDRESS _____

OCCUPATION _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____

OCCUPATION _____

ADDRESS _____

IS THIS JOB RELATED Yes No If yes, date _____

CITY _____ STATE _____ ZIP _____

IS THIS MOTOR VEHICLE RELATED? Yes No

CHECK (ONE) SPOUSE PARENT

IF YES, DATE OF ACCIDENT _____

RELATIVE CARE GIVER SIGNIFICANT OTHER

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information for both carriers. Please list all numbers on your card(s). If you have a 3rd insurance please advise receptionist.

Primary Insurance Name _____ Secondary Insurance Name _____

Address _____ Address _____

Phone # _____ Phone # _____

Policy Holder/Subscriber

Policy Holder/Subscriber

Name _____

Name _____

Relationship of Patient to Subscriber _____

Relationship of Patient to Subscriber _____

Self _____ Spouse _____ Child _____ Other _____

Self _____ Spouse _____ Child _____ Other _____

Insured ID No. _____

Insured ID No. _____

Group No. & Company Name _____

Group No. & Company Name _____

Policy Holder's Birth Date _____

Policy Holder's Birth Date _____

*** Contact in case of emergency (someone not residing with you):**

Name: _____ Address: _____

Phone: _____ Relationship _____

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand I AM FINANCIALLY RESPONSIBLE for any balance not covered by my insurance carrier. In the event my account is placed for collection with an attorney or agency, I will pay collection fees (33 1/3% of balance)

A copy of this signature is valid as the original.

Signature **X** _____