

**PATIENT INFORMATION:**

NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
*Last name, First Name, Middle Initial*

ADDRESS: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
\_\_\_\_\_  
*City, State, Zip code* CELL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

In Case of Emergency, please notify: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to us?

Yellow page ad     Another doctor     One of our patients     website \_\_\_\_\_

**PRIMARY INSURANCE**

INSURANCE CO: \_\_\_\_\_

SUBSCRIBER ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_

RELATION TO PATIENT: \_\_\_\_\_ SUBSCRIBER DATE OF BIRTH: \_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE CO: \_\_\_\_\_

SUBSCRIBER ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_

RELATION TO PATIENT: \_\_\_\_\_ SUBSCRIBER DATE OF BIRTH: \_\_\_\_\_

**I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.** I authorize you to release information necessary to process this claim, and I further authorize that payment of benefits be made directly to my physician. I have read all the information this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information. A photocopy of this authorization may be used in place of the original, and is valid until revoked in writing.

YES     NO    Permission to leave test results/procedures as a phone message

YES     NO    Permission to discuss test results/procedures with \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT (if minor): \_\_\_\_\_ DATE: \_\_\_\_\_