PATIENT INFORMATION
(Please print)

Name: _____ **DOB:** _____ **Age:** _____

Marital Status: _____ **Sex:** _____ **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____)_____ **Cell Phone:** (_____)_____

Employer Name: _____ **Work Phone:** (_____)_____

Address: _____

Referred By: _____

SPOUSE/PARENT INFORMATION

Name: _____ **Relationship:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____)_____ **Cell Phone:** (_____)_____

DOB: _____ **SSN:** _____

Employer: _____ **Work Phone:** (_____)_____

EMERGENCY NOTIFICATION

Name: _____ **Relationship:** _____

Address: _____

Home Phone: (____)_____ **Cell Phone:** (____)_____ **Wk Phone:** (____)_____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ **Phone:** (_____)_____

Address: _____

Subscriber Name: _____ **DOB:** _____

Policy/ID#: _____ **Group#:** _____ **SSN:** _____

AUTHORIZATION OF PAYMENT

I authorize payment of medical benefits to the physician or supplier for services rendered. I understand that I am financially responsible to the physician or supplier for charges not covered by the authorization.

Signature: _____ **Date:** _____