Doctor: ____________________

PATIENT INFORMATION

Name: ____________________

Address: ____________________

____

City,State, Zip: ____________________

Primary Phone: ____________________

Alt Phone: ____________________

Cell Phone: ____________________

Patient ID #: ____________________ Sex: [ ]M [ ]F

Date of Birth: ____________________ Age: ____________________

Sibling Name(s) and Date of Birth: ____________________ ____________________

____________________ ____________________

Social Security #: ____________________

Primary Physician: ____________________

CONTACT INFORMATION

Parent Name:	Relationship:	Date of Birth:	Phone:	Patient Lives With:
Parent Name:				

RESPONSIBLE PARTY *(If patient is under 18 years of age)*

Name: ____________________

Address: ____________________

____

City,State, Zip: ____________________

Employer: ____________________

Home Phone: ____________________

Work Phone: ____________________

SSN: ____________________

Date of Birth: ____________________

PRIMARY INSURANCE

Insurance Company Name: ____________________

ID #: ____________________ CoPay: ____________________

Group/Policy #: ____________________

Subscriber's Name: ____________________

Subscriber's Phone #: ____________________

Pt Relationship to Insured: ____________________

Subscriber's Employer: ____________________

Subscriber's SS #: ____________________

Subscriber's Date of Birth: ____________________

SECONDARY INSURANCE

Insurance Company Name: ____________________

ID #: ____________________

Group/Policy #: ____________________

Subscriber's Name: ____________________

Subscriber's Phone #: ____________________

Pt Relationship to Insured: ____________________

Subscriber's Employer: ____________________

Subscriber's SS #: ____________________

Subscriber's Date of Birth: ____________________

WORK RELATED INJURY

Only applicable if injury is related to work or auto accident

Insurance Carrier Name: ____________________ Address: ____________________

City, State, & Zip: ____________________ Phone: ____________________

Claim Number: ____________________ Date of Injury: ____________________ Employer @ time of Injury: ____________________

INSURANCE AUTHORIZATION AND ASSIGNMENT
(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for my entire bill unless this form is complete.***

____________________ ____________________

PATIENT/GUARDIAN SIGNATURE DATE

05/20/2010