PATIENT INFORMATION

Last Name ______________________ First Name ______________________ Middle Initial ________

Home Phone ____________ Mobile Phone ____________ Age ______ DOB ____________ Gender ______

Patient Address ____________________ Apt/Unit ____ City ____________ State ______ Zip Code _____

Race ________________ Ethnicity ____________________ Language Spoken ____________________

Email Address ____

Emergency Contact ____

Telephone ________________________________ Relationship ____________________________

Reason For Visit ____________________________ Referring Physician _______________________

RESPONSIBLE PARTY

Guarantor Name (Last, First, M.I.) ________________________ DOB ____________ Gender _____ SSN ____

Guarantor's Complete Address ____________________ Telephone ______________________________

INSURANCE INFORMATION

(1) Primary Insurance Company ____________________ Member ID ______________________________

Policy Holder's Name ________________ Relationship To Patient ________________ DOB ______ SSN ____

(2) Secondary Insurance Company __________________ Member ID ______________________________

Policy Number ____________________ Group Number ________________ Effective Date ______________

PHARMACY INFORMATION

Preferred Pharmacy ________________ Phone Number ______________________________________

Address _______________________ City ________________ State ______ Zip ______________

The above information is complete and correct. I hereby authorize the release of information necessary to file a claim with my insurance company, and I assign benefits otherwise payable to the doctor or group indicated on the claim. I understand that I am financially responsible for all charges for medical services rendered, regardless of insurance coverage. A copy of the signature is as valid as the original.

PATIENT/GUARDIAN SIGNATURE ____ DATE ______________

GUARANTOR SIGNATURE ____ DATE ______________

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