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 _____