PLEASE COMPLETE ENTIRE FORM

Today's Date: ______________________

Patient Information:

First Name: ______________________ MI: ________ Last Name: ______________________

Date of Birth: ________________ Soc. Sec. #: ________________ Marital Status: Single Married Divorced Widowed

Address: ______________________ City: ______________ State: _____ Zip Code: ________

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Preferred method of contact: HOME WORK CELL ***(CIRCLE ONE)*** IS IT OK TO LEAVE VOICEMAIL? YES NO ***(CIRCLE ONE)***

Preferred Pharmacy Name: ______________________ Pharmacy Phone: ______________________

Emergency Contact:

First Name: ________________ Last Name: ________________ Relationship to Patient: ____________

Best Contact Number: ________________ Alt. Phone Number: ________________

Yes/No Ok to leave voicemail **Yes/No** Ok to leave voicemail

Previous Primary Care Provider: ______________________ Office Phone: ______________________

May we contact your previous primary care provider for records? Yes No

How Did You Hear About Us: ____

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Insurance/Billing Information:

Primary Insurance:

Patient Employer Name: ______________________ Patient Employer Phone: ______________________

Patient Employer Address: ______________________ City: ______________ State: _____ Zip Code: ________

Insurance Name: ______________________ Customer/Member Service Phone: ______________________

Policy/ID #: ______________________ Group #: ______________________

Policyholder/Subscriber Name: ______________________ Date of Birth: ______________________

Policyholder/Subscriber Social Security #: ______________________ Relationship to patient: ________________

Secondary Insurance:

Insurance Name: ______________________ Customer/Member Service Phone: ______________________

Policy/ID #: ______________________ Group #: ______________________

Policyholder/Subscriber Name: ______________________ Date of Birth: ______________________

Policyholder/Subscriber Social Security #: ______________________ Relationship to patient: ________________

ALL PATIENTS/GUARANTORS: I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay direct to Provider, the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

____ ________________

Signature of Patient/Responsible Party Today's Date