PATIENT INFORMATION

Today's Date:____/____/____ **Doctor:**_____

Patient's Last Name:_____ First:_____ MI:____

Date of Birth:____/____/____ Age:_____ SSN:_____ Sex: M F

Street Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( )_____ E-mail Address:_____

IN CASE OF EMERGENCY

Name of relative or friend:_____ Home Phone: (___)_____ Cell Phone: (___)_____ Relationship to Patient:_____

GUARANTOR INFORMATION

Guarantor Last Name:_____ First:_____ MI:____ SSN:_____ Home Phone: ( )_____

Guarantor Address:_____ Guarantor Employer:_____ Occupation:_____

City:_____ State:_____ Zip:_____ Work Phone: (___)_____

INSURANCE INFORMATION

Primary Insurance Company:_____ Insurance Company Phone: (___)_____ Address: City:_____ ST:_____ Zip:_____

Subscriber Name:_____ Subscriber SSN:_____ Subscriber Birth Date:____/____/____ Policy Number:_____

Group Number:_____ Effective Date:____/____/____ Relationship to Patient:_____ Subscriber Employer:_____

Secondary Insurance Company:_____ Insurance Company Phone: (___)_____ Address: City:_____ ST:_____ Zip:_____

Subscriber Name:_____ Subscriber SSN:_____ Subscriber Birth Date:____/____/____ Policy Number:_____

Group Number:_____ Effective Date:____/____/____ Relationship to Patient:_____ Subscriber Employer:_____

The above information is complete and correct. I authorize treatment of the above named patient. I hereby authorize release of information necessary to file a claim with my Insurance company and I assign benefits otherwise payable to me to the doctor group indicated on the claim. All professional services rendered are charged to the patient. The Patient is responsible for all fees,regardless of Insurance coverage. In the event of collection proceedings due to lack of pament on my part, I agree to pay any and all collection fees that may be aded to my acount in order to recover monies due the doctor. A copy of the signature is as valid as the original.

Patient Signature:_____ Date:____/____/____ Guarantor Signature:_____ Date:____