Patient Information

Date: _____

Patient Last Name: _____ First Name: _____MI: _____

Address: _____ City _____State_____

Zip _____ Social Security # _____ Date of Birth _____

Home Ph _____ Cell Ph _____ Work Ph _____

Drivers License # _____ Marital Status: Married Single Widow Divorced

Sex: Male Female Preferred E-Mail Address: _____

Emergency Contact: _____ Phone _____

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

Preferred Pharmacy: _____ Phone _____

Person Responsible _____ Relationship _____

Address (if different than above) _____

City _____ State _____ Zip _____ Phone _____

Social Security # _____ Drivers License # _____

Insurance Information: *You must provide us with a current copy of your insurance card(s).*

Primary Insurance: _____ ID# _____

Group # _____ Policy Holder _____

Date of Birth _____ Social Security # _____ Relationship to Patient _____

Secondary Insurance: _____ ID# _____

Group # _____ Policy Holder_____

Date of Birth _____ Social Security # _____ Relationship to Patient_____

Vision Insurance _____

Release of Information/Assignment of Benefits/Consent to Treat

I authorize the use of this form on all insurance submissions and authorize release of information needed to process a claim to my insurance companies and permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in obtaining payment from my insurance companies but understand the provider is not responsible for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand it is my responsibility to know my insurance benefits and that I will receive a monthly statement for any balance due by me. All returned
checks will be assessed a $25 fee and will be prosecuted if not paid in full within 10 business days with a credit card or money order.

I consent to the medical and surgical care as deemed advisable by my physician.

Signature: _____**Date:**_____