



Patient Information

Section A. Responsible Party

Relationship to patient: _____ Self _____ Parent _____ Other _____
Name: First _____ M.I. _____ Last _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ Date of Birth: _____
Home Telephone: _____ Occupation: _____
Employer: _____ Telephone Number: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____

Section B. Patient Information

*If any information same as above, please indicate by writing "same" in appropriate section.

Patient's Legal Name: First _____ M.I. _____ Last _____
Nickname: _____ Patient SSN#: _____ Date of Birth: _____
Patient's Address: _____ City: _____ State: _____ Zip: _____
Patient's Home Telephone: _____ Patient's Occupation: _____
Sex: _____ Male _____ Female Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed
Allergies: _____
In case of emergency notify: _____ Telephone Number: _____
Are you employed?: _____ Yes _____ No If yes, _____ Full Time _____ Part Time
Employers: _____
Address: _____ City: _____ State: _____ Zip: _____

Section C. Primary Insurance Information

Name of Insured: _____ Date of Birth: _____
Employer of Insured: _____ Phone: _____
Name of Insured Company: _____
Certificate/ID#: _____ Group/Policy #: _____
Claim Mailing Address: _____ City: _____ State: _____ Zip: _____

Section D. Secondary Insurance Information

Name of Insured: _____ Date of Birth: _____
Employer of Insured: _____ Phone: _____
Name of Insured Company: _____
Certificate/ID#: _____ Group/Policy #: _____
Claim Mailing Address: _____ City: _____ State: _____ Zip: _____

Section E. Assignment of Insurance Benefits/Release of Medical Information:

I request that payment of my insurance benefits be made on my behalf to the clinic for any services furnished me by that group of physicians. I authorize any holder of medical information about me be released if needed to determine these benefits. I understand I am financially responsible for any balance not covered by insurance carrier.

Signed: _____ Date: _____