

Date \_\_\_\_\_

**PATIENT INFORMATION**  
PLEASE FILL OUT THIS FORM COMPLETELY  
AND SIGN WHERE INDICATED - PLEASE PRINT

NAME OF PATIENT \_\_\_\_\_  
Last Name First Name Middle Nickname

ADDRESS: \_\_\_\_\_  
STREET CITY ZIP CODE

DATE OF BIRTH \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
MONTH DAY YEAR

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SS# \_\_\_\_\_ CELL PHONE \_\_\_\_\_

SEX \_\_\_\_\_ MARRIED \_\_\_\_\_ DIVORCE \_\_\_\_\_ EMAIL: \_\_\_\_\_  
(check one) FEMALE \_\_\_\_\_ SINGLE \_\_\_\_\_ SEPARATED \_\_\_\_\_  
WIDOWED \_\_\_\_\_

YOUR PRIMARY PHYSICIAN: \_\_\_\_\_ WHO IS RESPONSIBLE FOR PAYMENT \_\_\_\_\_

**SPOUSE, PARENT OR GUARDIAN (Circle one)**

NAME \_\_\_\_\_  
LAST NAME FIRST INITIAL NICKNAME

ADDRESS: \_\_\_\_\_  
STREET CITY ZIP CODE

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

WORK PHONE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL NUMBER \_\_\_\_\_

**WHO REFERRED THE PATIENT TO US - PLEASE NAME BELOW**

REFERRING DOCTOR'S NAME | REFERRING PERSON'S NAME/ RELATIONSHIP/PHONE #

**INSURANCE INFORMATION**

In order to avoid error or delay in the processing of any insurance claims, it is essential that this section be COMPLETELY FILLED OUT.

Do you have health insurance to cover these services? YES NO (Circle one)

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

Insurance Company \_\_\_\_\_ Insurance Company \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ Ins. Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Phone Number \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder \_\_\_\_\_

Social Security No. \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security No. \_\_\_\_\_ Birth Date \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Group No. \_\_\_\_\_ ID No. \_\_\_\_\_ Group No. \_\_\_\_\_ ID No. \_\_\_\_\_

**Due to the large number of policies that come across our desk every day, we cannot possibly keep up with the specifics of each one. Therefore, we rely on you to know your insurance benefits. When you come in, we will make a copy of your insurance card to assure proper billing, but you should know when you need a referral and whether or not you have a co-pay.**

I authorize payment of medical benefits to undersigned physician or supplier for these services and all future claims.  
X \_\_\_\_\_

I authorize the release of any medical information necessary to process this claim and all future claims.  
X \_\_\_\_\_