Patient Information

Last Name	First Name	M	Referring Physician:
			Primary Care:

Address	City	State	Zip Code

Phone circle preferred contact number (Home)	(Cell)	Birthdate(MM/DD/YYYY) Male ☐ Female ☐

Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐	Social Security Number

Ethnicity Non-Hispanic or Non-Latino☐ Hispanic/Latino ☐	Race	Language ☐ English Other:_____

Contact Information

If you would like reminders and or confirmation regarding appointments, prescription refills or other information, please note your preferred method of communication. You may choose more than one.

Voice Message	Text	Email	Email Address:

Time of day you preferred to be contacted Circle one:	Morning	Afternoon	Evening

Employer Information

Occupation	Employer

Employer Address	City	State	Zip Code

Work Phone	Extension

Insurance Information on Primary

Insurance Company Name	Effective Date of Coverage	Co-Payment Amount

Address	City	State	Zip Code

ID/Policy Number	Group Number/Name

Subscriber/Insured Name	Relationship to Patient

Social Security Number	Birth Date (MM/DD/YYY)

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Insurance Information on Secondary

Insurance Company Name	Effective Date of Coverage	Co-Payment Amount

Address	City	State	Zip Code

ID/Policy Number	Group Number/Name

Subscriber/Insured Name	Relationship to Patient

Social Security Number	Birth Date (MM/DD/YYY)

Insurance Information on Secondary

Emergency Contact

Name #1	Relationship to Patient

Home Phone	Cell Phone	Work Phone

Name #2	Relationship to Patient

Home Phone	Cell Phone	Work Phone

Assignment and Release

Authorization to treatment and release information to insurance carrier for direct payment to the provider. I authorize treatment and the release of any medical information (acquired in my treatment) to process claims to my insurance company. I authorize direct payment from my insurance company to my provider. At any time I decide that I want to file my own claims, understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred.

Patient Signature _____ Date _____