

PATIENT INFORMATION

Name	First	Middle	Last				
<hr/>							
Address	Street	Apt	City	State	Zip		
<hr/>		<hr/>		<hr/>			
Area Code and Telephone Number		Emergency Contact Person		Emergency Contact Phone Number			
<hr/>		<hr/>		<hr/>			
DOB	_____/_____/_____ Month Day Year	Male or Female	_____ Marital Status	_____-_____-_____ Social Security	_____ Cell Phone		
<hr/>		<hr/>		<hr/>			
Primary Care Physician _____		Referral required from PCP? Yes No		Referring Physician if different _____			
<hr/>		<hr/>		<hr/>			
Employer Name	Address	City	State	Zip	Phone	Ext	
<hr/>		<hr/>		<hr/>		<hr/>	

GUARANTOR INFORMATION

Name	First	Middle	Last				
<hr/>							
Address	Street	Apt	City	State	Zip		
<hr/>		<hr/>		<hr/>			
Area Code and Telephone Number		Cell Phone	Social Security	Relationship to Patient			
<hr/>		<hr/>		<hr/>			
Employer Name	Address	City	State	Zip	Phone	Ext	
<hr/>		<hr/>		<hr/>		<hr/>	

PRIMARY INSURANCE: \*Must be completed in full along with a photo copy of the insurance card.

Insurance Name	Address	City	State	Zip	Phone		
Group # _____	Policy# _____	Relationship to Subscriber: _____					
<hr/>		<hr/>		<hr/>			
Subscriber Name _____		DOB _____	SS# _____				
<hr/>		<hr/>		<hr/>			
Employer Name	Address	City	State	Zip	Phone	Ext	
<hr/>		<hr/>		<hr/>		<hr/>	

SECONDARY INSURANCE: \*Must be completed in full along with a photo copy of the insurance card.

Insurance Name	Address	City	State	Zip	Phone
Group # _____	Policy# _____	Relationship to Subscriber: _____			

How did you come to select our practice? Check one:	_____ Dr. Referred	_____ Friend Referred	_____ Family Recommends
	_____ Yellow Pages	_____ Referral Service	_____ Newspaper

Subscriber Name _____		DOB _____	SS# _____		
<hr/>		<hr/>		<hr/>	
Employer Name	Address	City	State	Zip	Phone
<hr/>		<hr/>		<hr/>	

APPLIES TO MEDICARE PATIENTS ONLY: I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to provider for any services furnished me by their physicians. I authorize my holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. APPLIES TO MEDIGAP PATIENTS ONLY: I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to provider for any services furnished me by their physicians. I authorize any holder of medical information about me to release to my (Insurance Co. Name) \_\_\_\_\_ any information needed to determine these benefits payable for services.

ALL PATIENTS and/or GUARANTOR: I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay direct to Provider, the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in effect until such time as revoked by me. In the case of default payment, I promise to pay any legal interest on the balance due together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Signature of Patient or Guarantor \_\_\_\_\_ Date \_\_\_\_\_