PATIENT INFORMATION

_____
Family Doctor & Phone Number

_____
Name

SEX: Male or Female _____

_____
Street Address City State Zip Code

_____
Home Phone Number Work Phone Number Cell Phone Number or Add'l Phone Number

Date of Birth _____ Social Security Number _____ Marital Status _____

EMPLOYER/SCHOOL_____
Name

_____
Street Address City State Zip Code

IN CASE OF EMERGENCY/GUARDIAN (IF PATIENT IS A MINOR)

_____
Name Relationship Home Phone Number Other Phone Number

INSURANCE INFORMATION (This information is on your insurance card)

PRIMARY_____
Name of Insurance & ID# Type of Policy

SECONDARY _____
Name of Insurance & ID# Type of Policy

IF YOU HAVE OTHER INSURANCE PLEASE WRITE THE SAME INFORMATION ON BACK

****IF THIS IS NOT YOUR POLICY PLEASE SUPPLY US WITH THE SUBSRIBER INFORMATION, SO THAT THE INSURANCE CAN BE BILLED CORRECTLY****

_____
Policy Holder Name Relationship Date of Birth Social Security Number

_____
Street Address City State Zip code Phone Number

_____ _____
Employer Phone Number

_____
Street Address City State Zip Code

****I UNDERSTAND THERE IS A $10 - $75 FEE FOR CANCELLATIONS WITHIN 24 HRS & FOR NO SHOWS.**

****I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO BRING MY COPAY & PAY ON OUTSTANDING BALANCES & BRING MY REFERRAL IF NEEDED FOR EACH VISIT.**

I VERIFY THAT THE ABOVE INFORMATION IS CORRECT:

_____ _____
PATIENT (GUARDIAN) SIGNATURE **DATE**

4/27/2011