PATIENT INFORMATION DOB: _____ Social Security #: _____

Name: _____ Sex [ ] Male Marital Status: [ ] Married [ ] Single

Mailing Address: _____ [ ] Female [ ] Divorced [ ] Widowed [ ] Other

City, State, ZIP: _____ Email Address: _____

Street Address: _____ Primary: [ ] Home [ ] Work [ ] Cell: _____

City, State, ZIP: _____ Secondary: [ ] Home [ ] Work [ ] Cell: _____

Primary Care Physician: _____ Ethnicity: Hispanic □ Non-Hispanic □

Veteran? Yes _____ No _____ Race: _____ Religion: _____

Spoken language _____ Interpreter needed Yes _____ No _____

PATIENT EMPLOYMENT [ ] Child

[ ] Employed [ ] Retired [ ] Unemployed [ ] Self

Employer: _____

Job Title: _____

Phone: _____

EMERGENCY / PERSONAL CONTACTS

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

GUARANTOR / RESPONSIBLE BILLING PARTY [ ] Same as Patient

Name: _____ Employer: _____

Address: _____ Work Phone: _____

City, State, ZIP: _____ Social Security #: _____

Phone: _____ Date of Birth: _____

PRIMARY INSURANCE Subscriber: [ ] Patient [ ] Responsible Billing Party [ ] Other

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____ Subscriber Social Security #: _____

Insurance Co.: _____ Insured ID: _____ Group #: _____

SECONDARY INSURANCE Subscriber: [ ] Patient [ ] Responsible Billing Party [ ] Other

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____ Subscriber Social Security #: _____

Insurance Co.: _____ Insured ID: _____ Group #: _____

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION: I GIVE MY CONSENT FOR TREATMENT.

I hereby authorize the release of any appropriate medical information to my insurance company. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans. This assignment will remain in effect until revoked by me in writing.

We make every reasonable effort to obtain pre-approval, prior authorization and referral information. Your co-payment, co-insurance and/or deductible are due in full at the time of service. We will bill your insurance as a courtesy to you. On denied workers compensation claims, the patient's private/group health insurance may be billed. Ultimately financial responsibility remains with the patient and if the insurance company or workers compensation carrier denies payment, the bill is your responsibility. If you are unsure of any of these issues, please ask the staff before you see the physician.

Signature: _____Date:_____