

**PATIENT'S INFORMATION**

Patient Name: \_\_\_\_\_ New Patient? Yes No  
(Last) (First) (M)  
Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Marital status: \_\_\_\_\_ Telephone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_  
(Cell): \_\_\_\_\_ Indicate Preferred Phone #: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**GUARANTOR**

Is patient the guarantor of this account? Yes No If no, please complete the following section . . .  
Guarantor's Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
(Last) (First) (M)  
Guarantor's Address: \_\_\_\_\_ DOB: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_  
Relationship to patient \_\_\_\_\_

**POLICY HOLDER (Primary Insurance)**

Is the patient the policy holder of this account? Yes No If no, please complete the following section  
Policy Holder's Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
(Last) (First) (M)  
Policy Holder's Address: \_\_\_\_\_ DOB: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Sex \_\_\_\_\_ Marital status \_\_\_\_\_  
Policy Holder's Employer \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_

**MEDICAL INSURANCE**

(Please present Medical Insurance ID Card to Receptionist) Effective Date: \_\_\_\_\_  
**Primary** Health Insurance Co. \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Plan # \_\_\_\_\_  
**Secondary** Health Insurance Co. \_\_\_\_\_  
Policy # \_\_\_\_\_ Group# \_\_\_\_\_ Plan # \_\_\_\_\_

**SIGNATURE ON FILE**

I hereby authorize you to pay directly to the above named doctor, benefits due me out of indemnity under the terms of my policy issued by my company. For Medicare beneficiaries: I authorize any holder of medical or other information about me to release to the social security administration, its intermediaries or carries and any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment above. For all others: I hereby authorize the undersigned physician to release any information acquired in the course of my examination to treatment. Payment is authorized upon receipt of this itemized statement for services rendered to me. This policy was in full force and effect at the time that these services were rendered. Payment of the amount as herein directed, in whole or in part shall be considered the same as if paid by your company directly to me.

LEGAL SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_