______________________________ ______________________ ______ ____________________ Gender: Male/Female
Last Name First Name MI Preferred Name

_____/_____/_______ ______-____-_______ ________________________________ Marital Status: M/S/D/W/Other
Date of Birth SSN Race/Ethnicity

____ ____________________ _______ ___________
Mailing Address City State Zip

(____)__________________ (____)_____________________ (____)_____________________
Home Phone Work Phone Cell Phone

____ Preferred Method of Contact: Home/Work/Cell/E-mail
E-Mail

____ ____
Employer/School Occupation/Grade

__________________________________ _______________________________ _____/_____/______
Parent/Guardian Last Name (if minor) First Name Date of Birth

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Primary Insurance Information:

Policy holder name: ____ DOB:_____/_____/_____

Ins. Name: ______________________________________ Employer:_______________________________

Relation to Patient: _______________________

ID________________________________ Group #_______________________

Secondary Insurance Information:

Policy holder name: ____ DOB:_____/_____/_____

Ins. Name: ______________________________________ Employer:_______________________________

Relation to Patient: _______________________

ID________________________________ Group #______________________

Please Read: Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. I understand (even if I do not have insurance) that I will be financially responsible for payment of all charges incurred for services from this office. I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefit either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for the services rendered.

Signature:____ Date:________________________