

PATIENT INFORMATION

Name: _____

Last

First

Middle

Mailing Address: _____

Street Address, City, State, Zip Code

Home Phone No: _____ Cell No: _____

Work No: _____ Date of Birth: _____ Social Security Number: _____ - _____ - _____

 Male Female Single Married Divorced Separated Widowed Domestic Partner Dependent Child

Employer: _____

FAMILY INFORMATION

Check one: Spouse of patient Domestic Partner of patient Parent of patient Other: _____

Name: _____

Last

First

Middle

Mailing Address: _____

Street Address, City, State, Zip Code

Phone Number: _____ Date of Birth: _____

Employer: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship to Patient: _____

Mailing Address: _____

Street Address, City, State, Zip Code

INSURANCE INFORMATION

Insurance Company #1: _____ Policy Holder: _____

(Have card available for receptionist to photocopy)

Insurance Company #2: _____ Policy Holder: _____

(Have card available for receptionist to photocopy)

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I authorize physician and clinic to release any information to process insurance claims. I also authorize my insurance claim to be paid directly to the clinic, unless otherwise specified.

Patient Signature: _____ **Date:** _____