Patient Information

Patient Name:
First_____MI_____Last_____
Address
_____Zip_____City_____State_____
Phone Number
Home_____Cell_____ Work_____

Sex: **M/F** DOB:____/___/____ SSN:_____/____/_____ Marital Status: **S/M/D/W** Employed **Yes/No**

Employer:
Name_____Address_____
City_____St:_____Zip code:_____Phone#:_____

Spouse Name:_____ DOB:_____/_____/_____ SS#_____
Employer:_____Address_____Phone:_____

Emergency Contact:
Name:_____Relationship:_____Phone:_____
Address:_____City:_____St:_____Zip:_____

Primary Language :_____ **Secondary Language**:_____

Insurance Information: **(Please attach Insurance Card)**
Primary
Insurance Co:_____Policy #_____Grp_____
Subcriber Full Name:_____Relationship to Patient:_____
Sex: **M/F** DOB :_____/_____/_____ SS#:_____
Secondary
Insurance Co:_____Policy#_____Grp_____
Subscriber Full Name:_____Relationship to Patient:_____
Sex: **M/F** DOB :____ /_____/_____ SS#:_____

Please also complete this section if patient is a minor child or COLLEGE STUDENT

Responsible Party: Please circle: Mother/Father/Other:_____
Mothers Full Name:_____Maiden Name:_____
SS#_____ Date of Birth:_____
Address:_____City:_____St:_____Zip:_____
Phone:
Home_____Cell_____Work_____
Employer:
Name_____ Address_____
City_____State_____Zip_____

Fathers Full Name:_____
SS#_____ Date of Birth:_____
Phone:
Home_____Cell_____Work_____
Employer:
Name_____ Address_____
City_____State_____Zip_____

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare and Medicaid), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider with signature below. **I acknowledge that interest or a late fee, at the providers current rate, may be charged on all balances owing to the provider that are past due.**
I permit a copy of this release to be used in place of the original.

Signature:_____ Date:_____