PLEASE FILL OUT THE FOLLOWING INFORMATION ACCURATELY. PLEASE PRINT. BLACK INK ONLY.

PATIENT INFORMATION

______________________________ Name (Last, First, MI)

Male / Female — Gender

______________________________ Social Security Number

______________________________ Street Address

____________ Date of Birth

M/S/D/W — Marital Status

______________________________ City, State, Zip

______________________________ Drivers License Number

(   ) ____________ Home Number

(   ) ____________ Work Number

(   ) ____________ Cell/Pager/Other #

Referring Doctor______________________________

Patient Employer Name______________________________

INSURANCE INFORMATION (Please present insurance card & valid ID at time of check in)

Primary

Ins. Co. Name______________________________

Name of Insured______________________________

Date of Birth______________________________

Insured's ID #______________________________

Group #______________________________

Relationship of patient to the insured____________

Employer Name______________________________

Secondary

Ins. Co. Name______________________________

Name of Insured______________________________

Date of Birth______________________________

Insured's ID #______________________________

Group #______________________________

Relationship of patient to the insured____________

Employer Name______________________________

Do you have any other insurance? ☐ Yes ☐ No If yes, please list: ______________________________

Other family members who are patients:______________________________

______________________________ **Responsible Party's Name**

______________________________ **Address if different from above**

- **I understand that I am responsible for my co-payment and/or deductible. If applicable, at each visit. I understand that failure to pay this at the time service is rendered is a violation of my contract with my insurance company.**
- **I understand that at each visit I need to inform this office of any changes of insurance, addresses, phone numbers, etc. If I do not update the office, and the insurance is filed incorrectly as a result, I understand that I am responsible for the charges incurred.**
- **I understand that by signing this form, I am giving permission for my doctor to collect payment due from my insurance company for services performed. I understand the medical records will remain confidential as described in the Notice of Privacy Practices.**
- **If your account is turned over to collections, a $30.00 collection fee will be added.**
- **Please note there will be a $30.00 fee for returned checks.**

Emergency Contact name/number______________________________

I allow release of medical information to the following: (Please check all that apply)

_______ No one except myself

_______ Spouse: ______________________________

_______ Other: ______________________________

______________________________ Signature (Parent or legal guardian, if patient is a minor)

______________________________ Date