PATIENT INFORMATION

Last Name ______________________ First Name ______________________ Middle Initial __________

Home Phone ____________ Mobile Phone ____________ Age ________ DOB ____________ Gender ________

Patient Address ______________________ Apt/Unit _____ City ____________ State ________ Zip Code ________

Race __________________ Ethnicity ____________________ Language Spoken ______________________

Email Address ____

Emergency Contact ____

Telephone ________________________________ Relationship ______________________________

Reason For Visit ___________________________ Referring Physician __________________________

RESPONSIBLE PARTY

Guarantor Name (Last, First, M.I.) __________________________ DOB ____________ Gender _____ SSN _____

Guarantor's Complete Address ______________________ Telephone ______________________________

INSURANCE INFORMATION

(1) Primary Insurance Company ______________________ Member ID ______________________________

Policy Holder's Name __________________ Relationship To Patient ________________ DOB ________ SSN _____

(2) Secondary Insurance Company ____________________ Member ID ______________________________

Policy Number ______________________ Group Number ________________ Effective Date ______________

PHARMACY INFORMATION

Preferred Pharmacy __________________ Phone Number ____

Address __________________________ City __________________ State ________ Zip ________________

The above information is complete and correct. I hereby authorize the release of information necessary to file a claim with my insurance company, and I assign benefits otherwise payable to the doctor or group indicated on the claim. I understand that I am financially responsible for all charges for medical services rendered, regardless of insurance coverage. A copy of the signature is as valid as the original.

PATIENT/GUARDIAN SIGNATURE ____ DATE ______________

GUARANTOR SIGNATURE ____ DATE ______________