## PATIENT INFORMATION

SOCIAL SECURITY#:_____-_____-_____ SEX: **M** / **F** DATE OF BIRTH:_____/_____/_____

FIRST NAME:_____ MI:_____ LAST NAME:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ MOBILE:_____ WORK:_____

EMPLOYER:_____ ADDRESS:_____

## EMERGENCY CONTACT

FIRST NAME:_____ MI:_____ LAST NAME:_____

RELATIONSHIP:_____ HOME PHONE:_____ MOBILE:_____

## PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY:_____ CARDHOLDER NAME::_____

RELATIONSHIP TO PATIENT:_____ CARDHOLDER DATE OF BIRTH:_____/_____/_____

POLICY ID#:_____ GROUP #:_____ PHONE#:_____

## SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY:_____ CARDHOLDER NAME::_____

RELATIONSHIP TO PATIENT:_____ CARDHOLDER DATE OF BIRTH:_____/_____/_____

POLICY ID#:_____ GROUP #:_____ PHONE#:_____

## THIRD PARTY INSURANCE INFORMATION

INSURANCE COMPANY:_____ CARDHOLDER NAME::_____

POLICY ID#:_____ GROUP #:_____ PHONE#:_____

IF INJURED IN AN AUTO ACCIDENT, PLEASE PROVIDE DATE OF ACCIDENT: _____/_____/_____

## WORKERS' COMPENSATION INFORMATION

(IF INJURED ON THE JOB)

EMPLOYER NAME:_____ EMPLOYER ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SUPERVISOR NAME:_____ PHONE:_____ CLAIM #:_____

## GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY#:_____-_____-_____ SEX: **M** / **F** DATE OF BIRTH:_____/_____/_____

FIRST NAME:_____ MI:_____ LAST NAME:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ MOBILE:_____ WORK:_____

EMPLOYER:_____ ADDRESS:_____

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay all non-covered services.

**ACKNOWLEDGEMENT – RECEIPT OF NOTICE OF PRIVACY PRACTICES**: By my signature, I acknowledge receipt of the provider's Notice of Privacy Practices and have been given the opportunity to read it.

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**: I hereby authorize the above mentioned health care provider to receive and/or disclose my medical records for medical purposes only to either a physician's office or my insurance company without further written permission.

**SIGNATURE:_____ DATE:_____**