

# PATIENT INFORMATION

Please Print. All information will be confidential

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

SSN:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Email	Birthdate
Race, ethnicity	<input type="checkbox"/> Single <input type="checkbox"/> Married
Preferred Language	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Home Address	City, State, ZIP
Home Phone	Cell Phone
Emergency Contact	Emergency contact Phone
Employer	Work Phone
Primary Care Physician	Preferred Pharmacy

## Insurance Information

Name of insured:	
Relationship to Patient:	
Birthdate of insured:	SSN:
Insurance Company:	Insurance Phone #
Insurance ID #:	Group #
Copay / Deductible:	

## Secondary Insurance

Name of Insured:	
Relationship to patient:	
Birthdate of insured:	SSN:
Insurance Company:	Insurance Phone #
Insurance ID #	Group #
Copay / Deducible:	

### Authorization & Release

I authorize the release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize my insurance to be billed and benefits paid directly to the doctor. I understand that I am financially responsible for any balance whether or not covered and/or paid by my insurance. All copays, deductibles and/or estimated costs are due at the time of service. Please be aware that your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If your insurance company does not pay your claim in a timely manner, the balance will be your responsibility.

X \_\_\_\_\_  
(Patient signature or legal representative)

Date \_\_\_\_\_