PATIENT'S INFORMATION

NAME: _____
LAST FIRST MI

SOCIAL SECURITY#: _____-_____-_____ **DATE OF BIRTH:** _____

EMAIL ADDRESS: _____

ADDRESS: _____

_____
CITY STATE ZIP

HOME PHONE: _____ **CELL PHONE:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

DRIVER LICENSE #: _____ **(PHOTOCOPY WILL BE NEEDED)**

EMPLOYER: _____ **PHONE:** _____

ADDRESS: _____

_____
CITY STATE ZIP

MEDICAL PHYSICIAN: _____ **PHONE:** _____

REFERRING PHYSICIAN: _____ **PHONE:** _____

PHARMARCY NAME: _____

PHONE: _____ **FAX:** _____

ADDRESS: _____

_____
CITY STATE ZIP

PRIMARY INSURANCE: _____ **PHONE#:** _____

GROUP#: _____ **POLICY#:** _____

SECONDARY INSURANCE: _____ **PHONE#:** _____

GROUP#: _____ **POLICY#:** _____

RELATIONSHIP TO POLICY HOLDER: ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** _____

I authorize release of any and all information of my insurance companies or Medicare and permit a copy of authorization to be used in place of the original.

I authorize my doctor to act as my agent to file claims, assist in obtaining payment from my insurance company (ies) and authorize payment directly to my physician or to the party who accepts assignment.

I understand that I am responsible for my billing, including co-payments and deductibles. I further understand and agree to pay all costs and reasonable attorney's fees or agency fees if any charges for services rendered are placed with an attorney or collection agency. In the event of non-coverage, I agree to assume responsibility for payment should my insurance decline payment or if Medicare payment is denied.

PATIENT'S SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____
(IF MINOR)