

**WELCOME TO OUR OFFICE  
PATIENT INFORMATION**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

GOES BY \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

BUSINESS PHONE ( ) \_\_\_\_\_ REFERRED BY \_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_ PHONE \_\_\_\_\_ EXT \_\_\_\_\_

**RESPONSIBLE PARTY (IF NOT THE SAME AS ABOVE)**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY NAME \_\_\_\_\_

CLAIM ADDRESS \_\_\_\_\_

CLAIM PHONE NUMBER ( ) \_\_\_\_\_

ID #/POLICY# \_\_\_\_\_

GROUP # \_\_\_\_\_ COPAY AMOUNT \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

INSURED NAME \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

SECONDARY INSURANCE COMPANY  
NAME \_\_\_\_\_

CLAIM  
ADDRESS \_\_\_\_\_

CLAIM PHONE NUMBER (    ) \_\_\_\_\_

ID #/POLICY # \_\_\_\_\_

GROUP # \_\_\_\_\_ COPAY AMOUNT \_\_\_\_\_

DEDUCTIBLE INFORMATION \$ \_\_\_\_\_

INSURED NAME \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

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I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Finance Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to my physician. Regulations pertaining to medical assignment of benefits apply. I understand that I am financially responsible to the physician for charges not covered by this agreement or that which is above the usual and customary determined by my insurance company.

Signed \_\_\_\_\_ Date \_\_\_\_\_