Patient Information

Patient's Name: ______________________________ Age: __________

Street Address: ______________________________

City: ______________ State: __________ Zip: __________

Home Phone #: __________ Work Phone #: __________ Cell Phone #: __________

Date of Birth: __________ Social Security #: __________ Sex: M F

E-Mail Address: ______________________________

Marital Status: ______________ Patient's Employer: ______________

Referring Physician: ______________ Primary Care Physician: ______________

Emergency Contact: ______________ Emergency Phone #: ______________

Pharmacy: ______________ Pharmacy #: ______________

Race: ______________

Language: ______________

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unreported/Refused to Report

Preferred Method of Contact: ☐ Phone ☐ Postal Mail ☐ Web Message

Insurance Information: (The receptionist will make a copy of your card at every visit)

Primary Insurance: ______________________________

Policy ID #: ______________ Group #: ______________

Subscriber's Name: ______________ Subscriber's DOB: ______________

Secondary Insurance: ______________________________

Policy ID #: ______________ Group #: ______________

Subscriber's Name: ______________ Subscriber's DOB: ______________

Signature of patient or authorized person

I hereby authorize release of medical information necessary to report a claim to my plan(s). I hereby assign benefits otherwise payable to me to the physician indicated on the claim. I understand I am financially responsible for services not covered by my insurance plan.

Signature ______________________________ Date ______________

Medicare patients

I request that payment of authorized Medicare benefits be made to my physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I also understand that I am responsible for payment for services not covered by the Medicare program.

Signature ______________________________ Date ______________