

PATIENT INFORMATION

Social Security # _____

Home Address _____

First Name _____ Middle _____

City _____ State _____ Zip _____

Last Name _____

Email _____

Male Female Date of Birth ____ / ____ / ____

Primary Phone (____) _____

Marital Status Married Single Divorced Widowed

Other Phone (____) _____

Employer _____

Driver's License # _____

INSURANCE INFORMATION

Please provide your insurance card(s) to the receptionist

Insurance Company _____

Insured/Card Holder's Name _____ Date of Birth ____ / ____ / ____

Relationship to patient _____ Employer's Name _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____

Insured/Card Holder's Name _____ Date of Birth ____ / ____ / ____

Relationship to patient _____ Employer's Name _____

EMERGENCY CONTACT

First Name _____ Middle _____

Relationship _____

Last Name _____

Primary Phone (____) _____

GUARANTOR / RESPONSIBLE PARTY

Social Security OR Driver's License # _____

Address _____

Relationship _____

City _____ State _____ Zip _____

First Name _____ Middle _____

Male Female Date of Birth ____ / ____ / ____

Last Name _____

Primary Phone (____) _____

SIGNATURE BLOCK

I understand that medical treatment will be performed by licensed health care professionals and their staff. I hereby give my **consent for treatment** and affirm that no guarantee has been made as to the results of such treatment. I authorize PHYSICIANS to **release to my insurance carrier** any information necessary to process insurance claims on my behalf. I authorize my insurance carrier to make payments for medical benefits received directly to PHYSICIANS. I acknowledge that **I have received, read, and understood** a copy of PHYSICIANS Financial Information Sheet. **I agree to accept full financial responsibility** for that part of my health care expense, including co-payments, for which my insurance will not pay.

Patient Signature _____ Date _____