

Referred By: _____

Drivers Lic. #: _____

Soc. Sec. #: _____

Home # (_____) _____

Work # (_____) _____

Cell # (_____) _____

E-mail _____

@ _____ .COM

Patient Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Please circle marital status: Single , Married , Separated , Divorced or Widowed

Employer _____ Occupation _____

Is insurance provided through your employer? Yes No Through your husband's employer? Yes No

Husband's Name _____ Soc. Sec. # _____ Date of Birth _____

Employer _____ Occupation _____ Phone _____

Nearest relative not listed above _____ Relationship _____

Address _____ Phone _____

Person to notify in emergency if none of the people above can be reached _____

Address _____ Phone _____

FEE POLICY: To control costs we ask patients to pay their co-payment at the time of service.

MEDICAL RECORD RELEASE/ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, including major medical benefits that I am entitled to: Medicare, private insurance, and any other health plans, to the physician(s). This assignment remains in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges if covered or not or paid by said benefits as well as all collection fees and legal fees incurred in a collection process. I hereby authorize said assignee to release all information necessary to secure payment.

DATE _____ SIGNED _____