

Patient Information

Name: _____ Today's Date: _____
 Address: _____ City/State/Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone _____
 Marital Status: Single ___ Married ___ Widowed: ___ Other ___ Date of Birth: _____
 Social Security #: _____ Email Address: _____
 Spouse Name: _____ Spouse Date of Birth: _____

Responsible Party Information:

Who is responsible for this account (if different from above):
 Name: _____
 Address: _____ City/State/Zip _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Where Employed: _____
 Work Address: _____
 Responsible Party's Social Security #: _____ Date of Birth: _____
 If patient is a minor, relationship to patient: _____

Insurance Information:

Primary **Medical** Insurance Company: _____
 Identification/Policy #: _____ Group # _____
 Name of Subscriber (primary person on insurance) _____ DOB _____
 Relationship to subscriber: Self ___ Spouse ___ Child ___ Other _____

Secondary **Medical** Insurance Company: _____
 Identification/Policy #: _____ Group # _____
 Name of Subscriber (primary person on insurance) _____ DOB _____
 Relationship to subscriber: Self ___ Spouse ___ Child ___ Other _____

Vision Insurance

Identification/Policy #: _____
 Name of Subscriber (primary person on insurance) _____ DOB _____
 Relationship to subscriber: Self ___ Spouse ___ Child ___ Other _____

Does your insurance require a referral from your primary care physician? Yes ___ No ___
 *****Please give receptionist your card to copy*****

Who is your primary physician? _____ City/State _____
 Referring Physician's Name: _____ City/State _____
 How did you hear about us? ___ Word of Mouth ___ Phone Book ___ Internet (search sites) ___ Insurance

AUTHORIZATION TO RELEASE INFORMATION/PAYMENT AGREEMENT

I authorize the release of medical information necessary to process insurance claims. A copy of this authorization may be used in place of the original. This authorization may be revoked upon my request in writing. I understand that I am responsible for all professional services and or supplies rendered to either myself or my dependant. I understand that this office will submit my insurance claim for me, as a courtesy, but that it be my responsibility to pay for services rendered. I further understand that if my insurance does not pay for services in full, it is my responsibility to pay for the non-covered, allowable charges within thirty days.

Date: _____ Patient or Responsible Party's Signature _____