

GENERAL PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential)

DATE _____

PATIENT'S LAST NAME FIRST NAME MIDDLE HOME PHONE

CURRENT STREET ADDRESS CITY STATE ZIP HOW LONG?

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS AT CURRENT ADDRESS)

SOCIAL SECURITY NUMBER DRIVER'S LICENSE NUMBER DATE OF BIRTH AGE

EMPLOYED BY EMPLOYER'S ADDRESS SEX: MALE FEMALE

WORK PHONE OCCUPATION WHO REFERRED YOU TO OUR OFFICE?

MARITAL STATUS: SINGLE MARRIED WIDOWED SEPARATED DIVORCED

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY RELATIONSHIP EMERGENCY PHONE

CURRENT STREET ADDRESS CITY STATE ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

ADDRESS GROUP OR LOCAL NUMBER

SUBSCRIBER'S NAME SUBSCRIBER'S SOCIAL SECURITY NUMBER SUBSCRIBER'S I.D. NUMBER

SUBSCRIBER'S RELATIONSHIP TO PATIENT: SELF SPOUSE OTHER

SECONDARY INSURANCE COMPANY

ADDRESS GROUP OR LOCAL NUMBER

SUBSCRIBER'S NAME SUBSCRIBER'S SOCIAL SECURITY NUMBER SUBSCRIBER'S I.D. NUMBER

SUBSCRIBER'S RELATIONSHIP TO PATIENT: SELF SPOUSE OTHER

INSURANCE ASSIGNMENT

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to the Doctor the amount(s) due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

PATIENT'S SIGNATURE DATE DATE

INSURED'S SIGNATURE DATE DOCTOR'S SIGNATURE