Please review and update the information below to the best of your ability

Patient Information

CURRENT PATIENT INFORMATION – PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security Number:
Patient Email:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient:
Date of Birth:
Social Security Number:
Phone:
Emergency Contact Information:
Name:
Relationship:
Phone:
Mobile Phone:

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than Patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:

Policy Information:

Patient's relationship to policy holder:
ID/Certification Number:
Policy/Group Number:

Secondary Insurance Information

Insurance Plan Name:

Policy Holder (if other than Patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:

Policy Information:

Patient's relationship to policy holder:
ID/Certification Number:
Policy/Group Number:

ASSIGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance.
- I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process this claim.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.

Signed _____ Date:_____