

PLEASE FILL OUT BOTH SIDES

Please Print

Cell Phone: _____

Date _____ Referred by _____ Marital Status (x one)
Family Physician: _____ S _____ M _____ Sep. _____ D _____ W _____

This section refers to **PATIENT ONLY**

This section refers to **SPOUSE or person responsible for billing other than self.**

NAME _____
BIRTHDATE ___/___/___ SS# ___/___/___
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE () _____
SEX _____ AGE _____ WORK # _____
DRIVER'S LICENSE NO. _____
EMPLOYER _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
OCCUPATION _____
IS THIS JOB RELATED? _____

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE () _____
WORK PHONE () _____
SS # ___/___/___ BIRTHDATE ___/___/___
RELATIONSHIP TO PATIENT _____
OCCUPATION _____
EMPLOYER _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
Check (one) Spouse Parent

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information for both carriers. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before coverage or pre-existing clauses. **IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION OR PRE-ADMISSION APPROVAL, IT IS YOUR RESPONSIBILITY TO INFORM US.**

Primary Insurance Name _____
Address _____
Phone # _____

Secondary Insurance Name _____
Address _____
Phone # _____

Policy Holder Name: _____
Relationship to Patient
Self _____ Spouse _____ Child _____ Other _____
Insured ID No. _____
Group No. and Company Name _____
Policy Holder's Birth Date: _____

Policy Holder Name: _____
Relationship to Patient
Self _____ Spouse _____ Child _____ Other _____
Insured ID No. _____
Group No. and Company Name _____
Policy Holder's Birth Date: _____

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand I AM FINANCIALLY RESPONSIBLE for any balance not covered by my insurance carrier. In the event my account is placed for collection with an attorney or agency. I will pay collection fees (33 1/3% of balance) and all court costs incurred to the doctor in addition to my balance. A copy of this signature is valid as the original.

Signature _____