

**Patient Information**

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Name \_\_\_\_\_ SS#/HIC/Patient I.D. \_\_\_\_\_  
Last Name First Name Middle Initial  
Address \_\_\_\_\_ E-mail \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex: M F Age \_\_\_\_\_ Birth date: \_\_\_\_\_ married widowed single separated divorced  
Patient Employer/ School \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer/ School Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
In Case of an emergency who should be notified? \_\_\_\_\_

**PRIMARY INSURANCE**

Person responsible for the account \_\_\_\_\_  
Last Name First Name Middle Initial  
Relationship to Patient \_\_\_\_\_ Birth date \_\_\_\_\_ SS# \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

**ADDITIONAL INSURANCE**

Is patient covered by additional insurance? YES NO  
Subscriber Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address (if different from patients) \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand Am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above -named Insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature Date \_\_\_\_\_

\_\_\_\_\_  
Please print name relationship to patient