CHART #: PROVIDER:

PATIENT INFORMATION (PLEASE COMPLETE ALL FIELDS)

PATIENT NAME: LAST FIRST MIDDLE

ADDRESS:

CITY: STATE: ZIP CODE:

HOME PHONE #: CELL PHONE # EMAIL:

DATE OF BIRTH: SOCIAL SECURITY NUMBER:

SEX: (circle one) FEMALE MALE

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PRIMARY CARE PHYSICIAN: REFERRED BY:

PHARMACY: (Name, city, cross streets)

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

MEMBER ID NUMBER: GROUP NUMBER:

SUBSCRIBER NAME: SUBSCRIBER DATE OF BIRTH:

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

COPAYMENT AMOUNT: $

SECONDARY INSURANCE COMPANY:

MEMBER NUMBER: GROUP NUMBER:

SUBSCRIBER NAME: SUBSCRIBER DATE OF BIRTH:

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

COPAYMENT AMOUNT: $

PATIENT/CUSTIODIAL PARENT SIGNATURE:

I hereby apply for treatment by the physcians of this practice and or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on behalf and I assign the benefits payable to which I am entitled to this practice. I understand that payment is due at the time of service and that I am financially responsible for all charges, whether or not paid by insurance. I have been given a copy of the HIPAA Privacy Statement.

______________________________ Signature of Patient / Parent / Guardian

______________ Date