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PATIENT INFORMATION
(PLEASE PRINT)

Patient Name: ____ Patient SSN# : ______________________

Patient's Date of Birth: _______/ _______/ _______ Age: ________ Marital Status: ______________________

Street Address: ____ Home Phone: (______) ________________

City, State, Zip: ____ Work Phone: (______) ________________

Patient's Employer: _______________________________________ Occupation: _________________________

Employer Address: ____ City, State, Zip: _____________________

Patient's Insurance Type: ___________________________________ Effective Date: ______________________

Name of Primary Doctor : ____

Name of Alternate/ Referring Doctor : ____

(FILL OUT THIS SECTION IF MARRIED)

Spouse Name: ____ Date of Birth: _____________________

Address: ____ SSN #: ___________________________

Spouse's Employer: ____ Occupation: _______________________

Work Phone Number (________) ________________________ Alternate Number (_____) ____________________

Guarantor's Name & Relationship to patient: ____

Referred by (if person other than doctor): ____

Case of Emergency Person: ____

Relationship: ________________________________ Phone # (________) ________________________________

I authorize the use of this form on all of my insurance submission.
I authorize release of information to all of my insurance companies.
I understand that I am responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.
I authorize payment directly made to my doctor.
I permit a copy of this authorization to be used in place of this original.

Patient Signature: ____ Date: _____________