

**PATIENT IDENTIFICATION**

Mr.  Mrs.  Miss  Ms. DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ SEX: M F Age \_\_\_\_\_  
Last First Middle

ADDRESS \_\_\_\_\_  
Street City State Zip

EMAIL \_\_\_\_\_

TEL. (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_  
Area code

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

ADDRESS \_\_\_\_\_ TEL. (\_\_\_\_\_) \_\_\_\_\_  
Street City State Zip Area code

SPOUSE'S NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_

SPOUSE'S ADDRESS \_\_\_\_\_  
Street City State Zip

SPOUSE'S EMPLOYER \_\_\_\_\_ TEL. (\_\_\_\_\_) \_\_\_\_\_  
Area code

NEXT OF KIN NOT LIVING WITH YOU \_\_\_\_\_  
Name Address Tel.

**IF THE PATIENT IS A MINOR, STUDENT OR ANOTHER PARTY RESPONSIBLE FOR PAYMENT**

RESPONSIBLE PARTY (GUARANTOR/S) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City State Zip

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ BUSINESS PHONE (\_\_\_\_\_) \_\_\_\_\_  
Area code Area code

**INSURANCE INFORMATION**

PRIMARY  MEDICARE  STATE WELFARE → IF YES, NAME OF INSURANCE \_\_\_\_\_

OTHER \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

I.D. # \_\_\_\_\_ DOB \_\_\_\_\_

Group # \_\_\_\_\_

SECONDARY  MEDICARE  STATE WELFARE → IF YES, NAME OF INSURANCE \_\_\_\_\_

OTHER \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

I.D. # \_\_\_\_\_ DOB \_\_\_\_\_

Group # \_\_\_\_\_

IS IT WORKMEN'S COMPENSATION? \_\_\_\_\_

IF YES — NAME OF YOUR COMPANY & CONTACT PERSON \_\_\_\_\_

REFERRING DOCTOR (IF ANY) \_\_\_\_\_  
Name Street City State

Primary Care Doctor \_\_\_\_\_

As a courtesy to you, our staff may, from time to time, complete and submit insurance forms. We do not charge you for performing these tasks and they are not part of the medical services we render to you. Accordingly, we cannot be responsible for errors or delay in the filling out and/or submission of insurance forms.

Regardless of any insurance coverage I/we may or may not have, it is my/our responsibility to pay the entire bill. In the event that this office needs to obtain legal assistance in collection of any unpaid balance I/we agree to pay costs and attorney fees, as allowable by law and acknowledge receipt of a photocopy of this agreement.

SIGNATURE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

Parent, Guardian, or responsible party

Authorization to release my medical records for billing purposes is granted by me.

SIGNATURE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

Parent, Guardian, or responsible party

**\*\* PLEASE PRESENT WELFARE CARD AT TIME OF EACH VISIT \*\***