

PATIENT INFORMATION

NAME: _____ BIRTHDATE: ____/____/____ DATE: ____/____/____

ADDRESS: _____ SOCIAL SECURITY# _____

CITY: _____ STATE _____ ZIP CODE _____

HOME TEL: _____ CELL PHONE: _____ WORK TEL: _____

EMPLOYER: _____

SPOUSES NAME: _____

CHECK ONE: SINGLE ___ MARRIED ___ WIDOWED ___ DIVORCED ___

REFERRING PHYSICIANS NAME: _____ PHONE # _____

ADDRESS: _____

FOR HMO PATIENTS, WE **MUST** HAVE YOUR PRIMARY PHYSICIANS NAME AND ADDRESS IF DIFFERENT FROM ABOVE

PRIMARY PHYSICIAN'S NAME AND ADDRESS: _____

PHONE :

REFERRING DOCTOR AND ADDRESS: _____

INSURANCE INFORMATION (MUST INCLUDE)

PRIMARY

INSURANCE COMPANY: _____ POLICY #: _____ GROUP # _____

NAME OF INSURED: _____ BIRTHDATE: _____

SECONDARY

INSURANCE COMPANY: _____ POLICY #: _____

NAME OF INSURED: _____

I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE. I UNDERSTAND THAT SERVICES PROVIDED ON BEHALF WILL BE BILLED TO THE ABOVE NAMED INSURANCE. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING ANY COPAY ON THE DATE OF SERVICE AS WELL AS ANY DEDUCTIBLE AS DESIGNATED BY MY AGREEMENT WITH THE INSURANCE CARRIER. I AGREE TO BE RESPONSIBLE FOR THE ENTIRE BILL IF THE ABOVE SUBMITTED CLAIM IS REJECTED.

PATIENT SIGNATURE _____ DATE _____