PATIENT INFORMATION:

First Name _____ MI _____ Last Name _____

Ms. Mr. Miss Dr. Mrs. Rev.

Home Address _____

Zip Code _____ City _____ State _____

Social Security Number _____

Date of Birth _____ Age _____ Marital Status _____ Sex _____

Referring Physician _____ Dr's Phone # _____

Home (_____) _____

Work (_____) _____

Emergency (_____) _____

Contact Name: _____

Pager (_____) _____

Mobile (_____) _____

Fax (_____) _____

E:mail address _____

EMPLOYER INFORMATION:

Name of Company _____ Occupation _____

Address _____

Zip Code _____ City _____ State _____

Employer Contact Person: _____

Phone (_____) _____

FAX (_____) _____

Other (_____) _____

SPOUSE, PARENT OR RESPONSIBLE PARTY INFORMATION:

First Name _____ MI _____ Last Name _____ Relation to Patient _____

Social Security Number _____

Date of Birth _____ Age _____ Marital Status _____ Sex _____

Employer Occupation _____

Home (_____) _____

Work (_____) _____

Emergency (_____) _____

Pager (_____) _____

INSURANCE INFORMATION: (Please include Medicare/Medicaid)

Primary Insurance Plan _____

Insurance ID _____

Insurance Group # _____

Relation to insurance holder _____

Name of insured _____
(as it appears on card)

Secondary Insurance Plan _____

Insurance ID _____

Insurance Group # _____

Relation to insurance holder _____

Name of insured _____
(as it appears on card)

HMO, POS, EPO Participants: I understand that without an authorization or referral from my insurance carrier I will be responsible for all charges incured.

I authorize release of any Medical Information necessary to process this claim or to another medical specialty for care and treatment and AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR SERVICE.

Patient's or Authorized Persons Signature _____ Date _____

Please present insurance cards & drivers license with this form for copies.