PATIENT INFORMATION **CONFIDENTIAL** File #: ____________________

(Please Print) Date: ______________________

Name:____ Home Phone #: ____________
Last MI First

Birthdate:________________ Social Security Number: ________________ Cell Phone #: ____________

Address:________________________________ City:______________ State:________ Zip: ________

Circle Appropriate Status: Minor Single Married Divorced Widowed Separated

Patient's Employer: ____ Work Phone: ____________ Ext: _____

Business Address:__________________________ City:______________ State:________ Zip: ________

Spouse Or Parent's Name: ______________ Employer: ____________ Work Phone: ____________ Ext: _____

Whom May We Thank For Referring You? ____

Person To Contact In Case Of An Emergency: __________________________Phone: ________________

E-Mail Address: ____

May We Send Normal Test Results And Other Information To This E-Mail Address? ________________________
Signature

INSURANCE INFORMATION

Name Of Insured:____Relationship To Patient: ________

Birthdate:__________ Social Security Number: ________________________Date Employed: ____________

Name Of Employer: ____Work Phone: ________________

Address Of Employer:__________________________ City:______________State:________ Zip: __________

Insurance Company:_________________________ ID #: ________________Group #: ________________

Ins. Co. Address:__________________________ City: ________________State:________ Zip: __________

Effective Date Of Insurance Policy:__________________________________

Does Your Insurance Require A Referral From Your Primary Care Physician? ☐ Yes ☐ No

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Do You Have Any Additional Insurance? ☐ **Yes** ☐ **No** **If Yes Complete The Following**

Name Of Insured:____Relationship To Patient: ________

Birthdate:__________ Social Security Number: ________________________Date Employed: ____________

Name Of Employer: ____Work Phone: ________________

Address Of Employer:__________________________ City:______________State:________ Zip: __________

Insurance Company:_________________________ ID #: ________________Group #: ________________

Ins. Co. Address:__________________________ City: ________________State:________ Zip: __________

Effective Date Of Insurance Policy:__________________________________

SIGNATURE ON FILE

In order to bill your insurance company for services rendered we need your signature on file.

- I authorize the use of this form on all my insurance submissions
- I authorize release of information to my insurance carrier
- I understand that I am responsible for my bill
- I release this office from all liabilities incurred due to non-reimbursed referrals
- I authorize the doctor to act as my agent to obtain payment
- I authorize payment directly to my doctor
- I permit a copy of this authorization to be used in place of the original

Signature: ____