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PATIENT INFORMATION
(General Insurance)

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Primary Phone: ( ) _____-_____ Date of Birth: _____

SS # _____-_____-_____ Sex: M☐ F☐ Marital Status: M☐ S☐ D☐ W☐

Email Address: _____

Employer Information:

☐ Employed Full Time ☐ Employed Part Time ☐ Student ☐ Disabled ☐ Retired

If employed, please complete the following:

Occupation: _____

Employer: _____

Address: _____

Work Phone: ( ) _____-_____ Ext: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____

Phone: ( ) _____-_____ Relationship: _____

Patient Signature Date

Authorization and release: I authorize payment of insurance benefits directly to the doctor. I authorize the doctor to release all information necessary to secure the payment benefits. I understand I am responsible for all costs of treatment, regardless of insurance coverage. If the patient has an HMO plan that requires a referral, the patient must call their family doctor to obtain prior to the office visit. If you do not have or obtain the referral, the doctor will see you with the understanding that you will be responsible for the entire amount.

(1) Primary Insurance Information:

Insurance Company: _____

Name of Insured: _____

Ins Co. Address:

_____

_____

Ins Co. Phone Number: _____

Policy #: _____Group #: _____

(2) Secondary Insurance Information:

Insurance Company: _____

Name of Insured: _____

Ins Co. Address:

_____

_____

Ins Co. Phone Number: _____

Policy #: _____ Group #: _____

(3) Physician Information:

Physician Name: _____

Physician Address: _____

Physician Phone Number: _____