

Patient Information

Please answer all questions fully

Date: _____

Account Number: _____

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PATIENT

Name (Last, First, MI)		Social Security		Birthdate		Sex	Home Phone	
Mailing Address		City		State	Zip		Marital Status	
Employer		City		State	Zip		Work Phone	

RESPONSIBLE PARTY

Name (Last, First, MI)		Social Security		Birthdate		Sex	Home Phone	
Mailing Address		City		State	Zip		Marital Status	
Employer		City		State	Zip		Work Phone	

PRIMARY PHYSICIAN				REFERRING PHYSICIAN			

INSURANCE INFORMATION

Primary Insurance Company		Subscriber's Name		Relationship		Policy Number		Group #	
Second Insurance Company		Subscriber's Name		Relationship		Policy Number		Group #	
Third Insurance Company		Subscriber's Name		Relationship		Policy Number		Group #	

EMERGENCY CONTACT INFORMATION

Contact Name		Relationship		Primary Phone Number		Secondary Phone Number	
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PATIENT RELEASE:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

SIGNATURE: _____

DATE: _____

(SIGNATURE OF INSURED OR AUTHORIZED PERSON, PATIENT OR PARENT IF MINOR)