Last Name First Name M.I.

Nickname Sex Male Female

Address Suite/Apt Number

City State Zip Code

Email

Home Phone Cell Phone Work Phone

Preferred Method of Contact Home phone Cell Phone Work Phone Email

Date of Birth SSN

Marital Status Single Married Divorced Widowed Partner

Employment Student Employed Not Employed Self Employed
Retired Military

Preferred Language

Ethnicity Hispanic or Latino Not Hispanic or Latino Decline to Specify

Race American Indian or Alaska Native Asian
Black or African American White
Decline to Specify Hawaiian / Other Pacific Islander

Emergency Contact Phone Number

Relationship

Primary Insurance ID # Group #

Subscriber's Name DOB SSN

Relationship to Patient

Secondary Insurance ID # Group #

Subscriber's Name DOB SSN

Relationship to Patient

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible, co-insurance, or balance not paid for by your insurance.
I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any medical information about me to be released to Centers for Medicare and Medicaid Services, its agents, or any insurance carrier I may have in order to determine these benefits or the benefits payable for related services.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature: ____ Date: _______________________