



PATIENT NAME: \_\_\_\_\_

LOCAL ADDRESS: \_\_\_\_\_

PERMANENT ADDRESS (IF DIFFERENT): \_\_\_\_\_

HOME TELEPHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_ EMAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ GENDER: MALE \_\_\_\_ FEMALE \_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE #: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ REASON FOR VISIT: \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHARMACY: \_\_\_\_\_ PHONE #: \_\_\_\_\_

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INSURANCE

PRIMARY INSURANCE: \_\_\_\_\_

MEMBER ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

POLICY HOLDER'S DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_/\_\_\_\_/\_\_\_\_

POLICY HOLDER'S EMAIL: \_\_\_\_\_ PHONE #: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

MEMBER ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

POLICY HOLDER'S DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_/\_\_\_\_/\_\_\_\_

POLICY HOLDER EMAIL: \_\_\_\_\_ PHONE #: \_\_\_\_\_

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I UNDERSTAND, BY SIGNING BELOW, I CERTIFY THAT I HAVE INSURANCE COVERAGE AS INDICATED ABOVE. I AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO INSURANCE AS NECESSARY FOR CLAIMS TO BE PROCESSED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR TREATMENT REGARDLESS OF INSURANCE COVERAGE.

X \_\_\_\_\_ DATE: \_\_\_\_\_