DATE-_____

NAME -_____ MALE FEMALE

BIRTH DATE____-____-_____AGE_____SOCIAL SECURITY#_____

ADDRESS _____
STREET CITY STATE ZIP CODE

HOME PHONE ( ) _____-_____ SINGLE MARRIED WIDOWED

CELL PHONE ( ) _____-_____

EMPLOYER NAME _____

EMPLOYER PHONE # ( ) _____-_____

NAME OF PARENT IF MINOR _____

NEAREST RELATIVE _____
PHONE #

FAMILY PHYSICIAN _____
NAME ADDRESS PHONE #

REFERRED BY _____

ADDRESS _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS AND AUTHORIZE PAYMENT OF BENEFITS TO THE PROVIDER MENTIONED BELOW. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE ON MY ACCOUNT IF THE INSURANCE REJECTS.

PATIENT SIGNATURE _____***DATE***_____/_____/_____

INSURANCE NAME _____

INSURANCE ADDRESS_____

SOCIAL SECURITY # OF SUBSCRIBER_____-_____-_____

DATE OF BIRTH FOR PRIMARY CARD HOLDER
(EXAMPLE) HUSBAND WIFE OR PARENT _____/_____/_____

DUE TO HIPPA REGULATIONS