PATIENT INFORMATION

Chart #:_______________________________

Patient Name____

S.S.Number ______________________ Age ________ Date of Birth _____ /_____ /_____

Home Phone ______________________ Business Phone ______________________

Home Address ____

Your Occupation ____

Your Employer ____

Referring Physician ____

Marital Status ______________________ Spouse's Name ______________________

Spouse's S.S. Number ______________________ Spouse's Employer ______________________

Business Phone ____

Name of nearest relative not living with you_______________________________

Address ______________________________ Phone ______________________

If you are a minor or if you live with your parents

Father's Name ______________________ Employer ______________________

Occupation ______________________ Business Phone ______________________

Mother's Name ______________________ Employer ______________________

Occupation ______________________ Business Phone ______________________

Insurance Information

Primary Insurance ______________________ Policy Holder ______________________

Address ______________________ Group Number ______________________

______________________ Policy Number______________________

Secondary Insurance ______________________ Policy Holder ______________________

Address ______________________ Group Number ______________________

______________________ Policy Number______________________

Authorization

I authorize the release of any medical records concerning me or my health to my insurance company. A photocopy of this authorization shall be valid as the original. I hereby assign payment directly to the physician for any benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

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Signature of Patient or Guardian (if minor)