Patient Information

Last name: _____ First Name: _____ Middle: _____ Date of Birth:_____

Sex at Birth: M____ F____ Race: _____ Ethnicity: _____

SSN: _____ Driver's License: _____ State: _____

Address: _____ City, State, Zip: _____

Cell Phone: _____ Alt Phone: _____

Work Phone: _____ Email address: _____

Marital Status: _____ Whom may we thank for referring you? _____

Employer: _____ Occupation: _____

(Circle One) Full-Time Part-Time Retired Student

Responsible Party (if different from above)

Name: _____ Sex: M____ F____ Date of Birth: _____

SSN: _____ Relationship to patient: _____

Address: _____ City, State, Zip: _____

Cell phone: _____ Work phone: _____

Preferred Phone: _____ Marital Status:_____

Employer: _____ Occupation: _____

Primary Insurance

Name of insurance company: _____

Policy #: _____ Group #: _____

Insurance Address: _____ City, State, Zip: _____

Name of Policyholder: _____ Relationship to patient: _____

SSN (If different from above): _____ Date of Birth: _____

Address: _____ Preferred Phone #:_____

Employer: _____ Occupation: _____ Work Phone:_____

Secondary Insurance (Only filed for Medicare Patients)

Name of insurance company: _____

Policy #: _____ Group #: _____

Insurance Address: _____ City, State, Zip: _____

Name of Policyholder: _____ Relationship to patient: _____

I certify that the above information is correct to the best of my knowledge. I certify that I, and/or my dependent(s) have coverage with the above insurance and assign directly to my provider all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE, per AWFC policies. I authorize use of my signature on all insurance claims. By signing this form, I am giving consent for medical treatment by my provider. This consent will end one year from the date signed below.

_____

Signature of Patient/Guardian Date