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Last Name _____ Primary Doctor _____

First Name _____ MI _____ Referring Doctor _____

Current Address_____ City_____ State_____ Zip_____

Phone _____ Work Phone _____ Cell Phone _____

Email address _____ Date of Birth _____ Sex: ☐ Male ☐Female

Social Security # _____ Age_____ Height_____ Weight_____

Allergies _____

Emergency Contact _____ Phone _____ Relationship _____

PRIMARY INSURANCE COMPANY _____ VERIFICATION REF #_____

Address _____Insurance # _____Group/Policy # _____

Subscriber relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

If different than patient:

Insured Name _____ Insured Date of Birth _____ Insured SS # _____

OFFICE USE ONLY: *In Network* ☐*Yes* ☐*No* *record all REMAINING amounts* *Visit Limits* _____

Co-payment _____ *Co-Insurance* _____ *Deductible* ---------- *Stop Loss* ---------- *Pre Cert/Auth* _____

SECONDARY INSURANCE COMPANY _____

Address _____Insurance # _____Group/Policy # _____

Subscriber relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

If different than patient:

Insured Name _____ Insured Date of Birth _____ Insured SS # _____

OFFICE USE ONLY: *In Network* ☐*Yes* ☐*No* *record all REMAINING amounts* *Visit Limits* _____

Co-payment _____ *Co-Insurance* _____ *Deductible* ---------- *Stop Loss* ---------- *Pre Cert/Auth* _____

Insured Employer Name _____ Occupation _____

Employer Phone Number _____ Employer Address _____

I hereby authorize and request my insurance company and/or third party insurance to pay directly to the doctor the amount(s) due on my claim of service(s) rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the doctor for payment of the entire bill. I authorize any holder of medical information about me to release to the health care financing administration and its agents, and/or any third party insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

Patient Signature _____ Date _____

Insured's Signature _____ Date _____

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Sign in Sheet

Signature	Date
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