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 _____________________________________