**Dr. Your Name**

123 Mallory Lane

New York, NY 11111

Phone : (555)555-5555

**Patient Information**

|  |  |
| --- | --- |
| Name: | |
| Date of Birth: | Phone #: |
| Address: | |
| City, State, Zip | |
| Email: | Emergency Contact: |
| Occupation: | Employer: |

**Insurance Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Insurance Name: | | | Insurance ID: | |
| Policy Holder Name: | | Group #: | | Date of Birth: |
| Relationship to Policy Holder:  🗌 Spouse 🗌 Parent | Is patient a minor:  🗌 Yes 🗌 No | | | |
| Parent/Guardian Name | | | Phone #: | |

**Pharmacy Information**

|  |  |
| --- | --- |
| Pharmacy | Phone # |
| Address |  |

**Medical History**

|  |
| --- |
| Current Medications: |
| Please list any medical conditions: |
| Reason for the visit:  🗌 Fever 🗌 Cough 🗌 Sore Throat 🗌 Body Aches 🗌 Dizziness 🗌 Shortness of breath 🗌 Headaches  🗌 Vomiting 🗌 Abdominal Pain 🗌 Tiredness 🗌 Weakness 🗌 Depression 🗌Hyper-active  🗌 Substance Abuse 🗌 Suicidal Thoughts 🗌 Self-Harm  🗌 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Signature on file & Authorization:**

I authorize the use of this form on all insurance submissions. I further authorize the release of information to my insurance carriers and/or managed care companies. I authorize [office name here] to act as my agent in obtaining payment from insurance carriers. I understand I am financially responsible for any non-covered services or unpaid balances. I authorize payment directly to [office name here], and I permit a copy of this authorization to be used in place of the original.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_