Today's Date:_____

PATIENT INFORMATION (please print – blue or black ink only)

Name:_____ Age:_____ Birth Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email Address:_____

Social Security #:_____ Male ☐ Female ☐

Primary Care Physician:_____

Employed? (circle one) Yes No **Full-time Student?** (circle one) Yes No

Employer:_____ Work Phone:_____ Occupation:_____

Work Address:_____ City:_____ State:_____ Zip:_____

Marital Status (circle one) Single Married Divorced Widowed **Who referred you here?**_____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

INSURANCE INFORFMATION

Primary Insurance Co Name:_____ Group #:_____ ID #_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Holder's Name:_____ Social Security Number:_____

Date of Birth:_____ Relation to Patient (circle one) Self Spouse Mother Father Other

Secondary Insurance Co Name:_____ Group #:_____ ID #_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Holder's Name:_____ Social Security Number:_____

Date of Birth:_____ Relation to Patient (circle one) Self Spouse Mother Father Other

I authorize the release of any medical information necessary to process insurance claims. My signature also authorizes payment of medical benefits to the named provider for professional services redered. I understand that I am finaincially responsible for all services rendered, that there is a $30 returned check fee and that 30% will be added to my balance if amy account must be referred to an agency for collection. We use Check Exchange for returned checks and I will be responsible for charges associated.

_____ _____

(Patient's Signature) (Date)