

PATIENT INFORMATION			
Name		Social Security Number (SSN)	Date of Birth
Home Address		City	State Zip
Mailing Address (if different from above)		City	State Zip
Daytime Phone		Evening Phone	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Spouse's name	Healthcare Proxy <input type="checkbox"/> Yes <input type="checkbox"/> No
E-mail address (optional)			
Referring Physician's Name & Address			
EMPLOYMENT INFORMATION			
Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer (Parent's employer if minor)	Occupation	
Employer's Address		City, State, Zip	Phone
Spouse's Employer		Spouse's SSN	
Spouse's Employer Address		City, State, Zip	Phone
RESPONSIBLE PARTY INFORMATION			
Person Responsible for Medical Expenses		Relationship to patient	Phone
Address		City	State Zip
PRIMARY INSURANCE INFORMATION			
Insurance Company	Policy Number	Medicare Number	Medicaid Number
Subscriber's name	Subscriber's Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:		
Address of Insurance Company			
SECONDARY INSURANCE INFORMATION			
Insurance Company	Policy Number	Medicare Number	Medicaid Number
Subscriber's name	Subscriber's Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:		
Address of Insurance Company			
EMERGENCY INFORMATION			
Person to Contact in Case of Emergency, Other than Spouse		Relationship to Patient	
Address	City	State Zip	Phone
AUTHORIZATION			
I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.			
Patient's Signature		Date	Spouse's Signature Date