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PATIENT INFORMATION

Name (First, M.I., Last) _____
 Address: _____ (City, State, Zip) _____
 Date of Birth: _____ Age: _____ Social Security # _____ Sex (M/F) _____
 Married/Single/Other Responsible Party _____ Relationship: _____
 Phone # _____ Cell # _____ Work # _____
 Employer & Occupation _____
 Reason for Today's Visit? _____
 How were you referred to us? Hospital/Physician/ Friend or Patient/ Other _____
 In case of an emergency, who should we notify? _____ Relationship _____
 Address: _____ Phone # _____
 Primary Care Physician: _____

PRIMARY INSURANCE

Insurance Company: _____ HMO PPO POS Indemnity
 Insured's Name: _____ Insured's Employer _____
 Insured's Date of Birth: _____ Insured's Social Security # _____
 Claim's Mailing Address: _____
 Insurance Telephone # _____ Group # _____

SECONDARY INSURANCE

Insurance Company: _____ HMO PPO POS Indemnity
 Insured's Name: _____ Insured's Employer _____
 Insured's Date of Birth: _____ Insured's Social Security # _____
 Claim's Mailing Address: _____
 Insurance Telephone # _____ Group # _____

Co-pays, deductibles and any other patient responsibility fees are due when services are rendered. If you have any questions about fees, please check with us prior to being seen. I understand that insurance will be filed by your office as a courtesy and does not constitute a contract between the physician and insurance company for payment of your services.

Patient Signature/ Authorized Guardian

Date