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Welcome to my office. Your cooperation in completing this form will enable me to provide you with the most appropriate assistance.

PATIENT INFORMATION

Date: ________________________

Name of Patient: ___________________________Age: ______ Date of Birth: _____________

Address: ____ Gender: ______

Marital Status: Married Single Other Employment: _________________________________

City: ____ State: _____________ Zip: __________

Home Phone: ___________________________ Mobile Phone: ____________________________

Can we leave messages? Which phone is preferred? _________________________________

Email address: ____

Permission to contact PCP: Y / N Address: and Phone ________________________________

EMERGENCY CONTACT

Name: __________________________________ Relationship to Patient: ___________________

Address: ____

City: ______________________________________ State: _____________ Zip: ________

Home Phone: ____________________________ Mobile Phone: ____________________________

Consent to contact if necessary? Y / N

INSURANCE INFORMATION

Insured's Name: ____________________________Date of Birth: ______________ Gender: ____

Insurance Company: ________________________ Ins. Co. Phone Number: ____________

Insurance Company Address: ____

Patient's Relationship to Insured: (Please circle one) Self / Spouse / Child / Other

Insured's Employer: ____

Insured's ID #: _______________________ Group or Policy #: ________________________

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment below.	I authorize payment of medical benefits to the undersigned physician or supplier for services.
Signed________________________________ Date__________	Signed____________________