

PATIENT INFORMATION		
FIRST NAME	LAST NAME	MINOR <input type="checkbox"/> Yes <input type="checkbox"/> No
SSN#	BIRTHDATE	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male
ADDRESS	CITY/STATE/ZIP	
PHONE NUMBERS and CONTACT PREFERENCE <input type="checkbox"/> Home() _____ <input type="checkbox"/> Day () _____ <input type="checkbox"/> Cell () _____ Should we need to contact you, what number would be your primary number. Okay to leave a message <input type="checkbox"/> Yes <input type="checkbox"/> No		
E MAIL		
EMPLOYER		
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		
RACE/ETHNICITY Federal Government Guidelines Requirement <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other		
RESPONSIBLE PARTY INFORMATION (if different than above)		
PRIMARY INSURANCE	ID#	GROUP#
FIRST NAME	LAST NAME	
BIRTHDATE	SSN	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male
ADDRESS	CITY/STATE/ZIP	
HOME PHONE	WORK PHONE	CELL PHONE
RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent, Child is Patient <input type="checkbox"/> Guardian <input type="checkbox"/> Significant Other <input type="checkbox"/> Other		
SECONDARY INSURANCE	ID#	GROUP#
FIRST NAME	LAST NAME	
BIRTHDATE	SSN	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male
ADDRESS	CITY/STATE/ZIP	
HOME PHONE	WORK PHONE	CELL PHONE
RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent, Child is Patient <input type="checkbox"/> Guardian <input type="checkbox"/> Significant Other <input type="checkbox"/> Other		
TERTIARY INSURANCE	ID#	GROUP#
NAME	BIRTHDATE	SSN
RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent, Child is Patient <input type="checkbox"/> Guardian <input type="checkbox"/> Significant Other <input type="checkbox"/> Other		

We will need to obtain copies of all insurance cards, so that we can file your insurance on your behalf.



I authorize release of any information concerning my (or child's) health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for all copays, coinsurances, and deductibles, due at the time services are rendered.

Signature of Responsible Party

Date