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PATIENT INFORMATION

Patient Name _____ DOB ____ / ____ / ____ SSN ____ - ____ - ____

Mailing Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ Cell Home Alternate Phone _____ Cell Home

Email** _____

Employer _____ Occupation _____

How you heard about us (Radio/TV/Friend/Family, etc.) _____

Sex Male Female Are you a veteran? Are you active or retired military?

Marital Status Married Single Widowed Divorced Spouse's Name _____ May we contact? Yes No

Ethnicity White or Caucasian Black or African American Asian Native American or Alaska Native
 Native Hawaiian or Other Pacific Islander Other Unknown I decline to answer

Parent/Legal Guardian (if not patient) _____

Emergency Contact
 Name _____ Phone _____ Relationship _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance _____ Policy Holder _____

Ins. Phone _____ Policy Holder's SSN ____ - ____ - ____

Policy # _____ Policy Holder's DOB ____ / ____ / ____

Group # _____ Policy Holder's Employer _____

SECONDARY INSURANCE

Insurance _____ Policy Holder _____

Ins. Phone _____ Policy Holder's SSN ____ - ____ - ____

Policy # _____ Policy Holder's DOB ____ / ____ / ____

Group # _____ Policy Holder's Employer _____

PATIENT PAYMENT AGREEMENT

I understand that I am responsible for my medical bill and accept responsibility for any charges not covered and paid by my insurance company or other third party resources.

- By signing below, I authorize the release of my medical records to the insurance carrier as may be necessary to determine benefits and to process claims for health care services provided to the above named patient.
- I authorize assignment of Medicare/Medicaid, other federal/state agents or any commercial insurance carriers to pay benefits directly to the provider of service(s).
- This is a Lifetime insurance authorization granting the provider authority to file claims on my behalf.

In addition to the above patient payment agreement, I sign below acknowledging receipt of the office's NOTICE OF PRIVACY PRACTICES

Signature _____ Date _____

Witness _____ Date _____

** Your email address will only be used to provide you information about events and classes we are hosting/sponsoring. We will not share this information.