



Account Number: \_\_\_\_\_

Physician: \_\_\_\_\_

Date: \_\_\_\_\_

**PATIENT INFORMATION**

Name				Employed or Student? <input type="checkbox"/> <input type="checkbox"/>		Full or Part Time? <input type="checkbox"/> <input type="checkbox"/>	
Address				Employer			
City, State, Zip				Address			
Home Phone Number ( )				City, State, Zip			
Date of Birth	Sex	Marital Status	Social Security #	Phone Number, Extension ( )			
Nickname			Email Address*				
Emergency Contact/Relationship				Phone Number			

**RESPONSIBLE PARTY INFORMATION**

Name		Phone Number ( )	
Address		Social Security Number	
City, State, Zip		Relationship to Patient	

**PRIMARY INSURANCE**

Name		Group #		Subscriber Name	
Address		Policy #		Relationship to Patient	
City, State, Zip		Primary Care Provider		Date of Birth	Sex
Phone Number for Benefits				Social Security Number	
Phone Number for Precertification		Employer		Employer Phone ( )	

**SECONDARY INSURANCE**

Name		Group #		Subscriber Name	
Address		Policy #		Relationship to Patient	
City, State, Zip		Primary Care Provider		Date of Birth	Sex
Phone Number for Benefits				Social Security Number	
Phone Number for Precertification		Employer		Employer Phone ( )	

**TERTIARY INSURANCE**

Name		Group #		Subscriber Name	
Address		Policy #		Relationship to Patient	
City, State, Zip		Primary Care Provider		Date of Birth	Sex
Phone Number for Benefits				Social Security Number	
Phone Number for Precertification		Employer		Employer Phone ( )	

How did you hear about us?

Referred by:

\*by providing us with an email address, you authorize us to contact you via email regarding your protected health information (PHI). If you do not wish to communicate by email, please leave this blank.

I certify that the information given by me as documented above is correct. I also certify that I have been given the following documents for review and that copies of these forms have been made available to me upon request.

**Financial Policy**(FP062706) **Notice of Privacy Practices** (NPP062706) **Non-Covered Services** (NCS062706)

By signing below, you are acknowledging that you have read and fully understand the above referenced documents.

Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_