



PATIENT IDENTIFICATION DATA

NAME: _____ S.S.#: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____
STREET CITY ZIP

HOME PHONE: _____ CELL PHONE: _____

BIRTH DATE: _____ SEX: _____ LANGUAGE: _____

RACE: _____ ETHNICITY: _____ STATUS: _____

EMERGENCY CONTACT: _____ (SMDW)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE: _____

INSURED'S INFORMATION:

NAME: _____ BIRTH DATE: _____

EMPLOYER: _____ WORK PHONE: _____

OCCUPATION: _____ S.S.#: _____

REFERRED TO US BY: _____
PHYSICIAN'S NAME

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INDIVIDUAL COVERAGE

Failing to comply with his suggestion could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company - and not between the insurance company and your doctor.

I authorize the release of any medical information necessary to process my claim and request payment of medical benefits

Signature: _____ Witness: _____