PLEASE PROVIDE US WITH THE FOLLOWING PERSONAL AND OTHER PERTINENT INFORMATION

Today's date _____

Name _____ Nick-name preferred: _____

Date of Birth _____ ☐ Male ☐ Female Soc.Sec # _____

Mailing Address _____

City, State, Zip _____ Home Phone _____

Occupation _____

Employer _____ Work Phone _____

Employer's Address : _____

City, St, Zip _____

Were you referred by ☐ Yourself ☐ Friend ☐ Insurance Carrier ☐ Primary physician ☐ Other physician

Name of person who referred you: _____ Their telephone # _____

If different from above, who is your family physician? _____ Phone # _____

FINANCIAL :	PRIMARY INSURANCE	SECONDARY PAYER OR RESPONSIBLE PARTY
NAME		
ADDRESS		
CITY,ST.ZIP		
POLICY #		
INSURED NAME		
RELATION		
SOC. SEC. #		
BIRTH-DATE		
GROUP #		
EMPLOYER NAME		

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

_____ _____

Signature Date