



PATIENT INFORMATION

Today's date: _____ PCP: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ Mr. Miss Mrs. Ms. Marital status (circle one)
Single / Mar / Div / Sep / Wid

Birth date: _____ Age: _____ Sex: _____ Cell Phone No.: _____

Street address: _____ Social Security no.: _____ Home phone no.: _____

P.O. box: _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____

Other family members seen here: _____

How did you hear about us? _____

INSURANCE INFORMATION

IF YOUR NEW BORN IS UNDER YOUR INS. PLEASE PUT YOUR INFO. HERE _____ (PLEASE GIVE OFFICE YOUR INS. CARD)

Person responsible for bill: _____ Birth date: _____ Address (if different): _____ Home phone/Cell phone: _____
_____/_____/_____ (_____)_____

Primary insurance Name : _____

Member ID : _____

Subscriber's name: _____ Subscriber's S.S. no.: _____ Birth date: _____ Group no.: _____ Co-payment: _____
_____/_____/_____ \$ _____

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group no.: _____ Policy no.: _____

IN CASE OF EMERGENCY

Name of local friend or relative _____ Relationship to patient: _____ Home phone no.: _____ Work phone no.: _____
_____ () _____ ()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _____

Date _____