

PATIENT INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL	
DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SSN			
MAILING ADDRESS		APT. #	CITY	STATE	ZIP
EMAIL		PRIMARY CARE PHYSICIAN			
LANGUAGE PREFERRED		RACE	ETHNICITY		
HOME PHONE		CELL PHONE	OTHER PHONE		
EMERGENCY CONTACT NAME		RELATIONSHIP	ADDRESS		
EMERGENCY CONTACT PHONE		GUARANTOR	GUARANTOR ADDRESS (if different than patient)		
PREFERRED METHOD OF CONTACT? <input type="checkbox"/> PHONE <input type="checkbox"/> EMAIL <input type="checkbox"/> MAIL			MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PAYMENT: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD		FINANCIALLY RESPONSIBLE PARTY: <input type="checkbox"/> PATIENT <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____			
REASON FOR VISIT _____ <small>(List Symptoms)</small>				WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ARE YOU OR IS THERE A POSSIBILITY YOU COULD BE PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO					

PLEASE PRESENT YOUR INSURANCE CARD AND DRIVERS LICENSE TO RECEPTIONIST

PRIMARY INSURANCE POLICY HOLDER

POLICY HOLDER'S NAME		SSN	DOB
INSURANCE NAME		INSURANCE I.D. #	
GROUP #	ADDRESS IF DIFFERENT THAN PATIENT'S	RELATIONSHIP TO POLICY HOLDER	

SECONDARY INSURANCE POLICY HOLDER (if applicable)

POLICY HOLDER'S NAME		SSN	DOB
INSURANCE NAME		INSURANCE I.D. #	
GROUP #	ADDRESS IF DIFFERENT THAN PATIENT'S	RELATIONSHIP TO POLICY HOLDER	

PLEASE READ AND SIGN

- I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ANY SERVICES RENDERED AT TIME OF VISIT.
Please note: You may incur separate charges for Laboratory and Orthopedic Services.
- I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY MY INSURANCE PLAN, INCLUDING MEDICARE.
- I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN FOR SERVICES RENDERED.
- I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: A DETAIL OF YOUR RIGHTS AND HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED IS SET FORTH IN THE NOTICE OF PRIVACY PRACTICES. A COPY HAS BEEN FURNISHED TO ME AND IS POSTED IN THE CLINIC.

PATIENT SIGNATURE _____ DATE _____