

**PATIENT INFORMATION:**

1. Name (Mr/Mrs/Miss/Ms) \_\_\_\_\_  
(Last) (First) (Mid. Init.)

2. Address: \_\_\_\_\_

3. City: \_\_\_\_\_ 4. State: \_\_\_\_\_ 5. Zip \_\_\_\_\_

6. Home Phone: ( ) \_\_\_\_\_ 7. Work Phone: ( ) \_\_\_\_\_ Ext.# \_\_\_\_\_

8. Employer: \_\_\_\_\_ 9. Occupation: \_\_\_\_\_

10. Driver's License: # \_\_\_\_\_ 11. S.S. # \_\_\_\_\_

12. Birthdate: \_\_\_\_\_ 13. Age: \_\_\_\_\_ 14. Sex: M F 15. Marital Status: M/S/D/W

16. Spouse's Name: \_\_\_\_\_ 17. Work Phone: ( ) \_\_\_\_\_

18. Referred by: \_\_\_\_\_  
(Name) (Address)

19. In Case of Emergency:  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_

**PERSON FINANCIALLY RESPONSIBLE: (Fill out only if different from patient)**

1. Name (Mr/Mrs/Miss/Ms) \_\_\_\_\_  
(Last) (First) (Mid. Init.)

2. Address: \_\_\_\_\_

3. City \_\_\_\_\_ 4. State: \_\_\_\_\_ 5. Zip \_\_\_\_\_

6. Home Phone: ( ) \_\_\_\_\_ 7. Work Phone: ( ) \_\_\_\_\_ Ext.# \_\_\_\_\_

8. Employer: \_\_\_\_\_ 9. Occupation: \_\_\_\_\_

10. Driver's License: # \_\_\_\_\_ 11. S.S. # \_\_\_\_\_

**INSURANCE INFORMATION:**

Medicare: \_\_\_\_\_ No \_\_\_\_\_ Yes # \_\_\_\_\_

Medical: \_\_\_\_\_ No \_\_\_\_\_ Yes # \_\_\_\_\_

Insurance Co. \_\_\_\_\_  
(Name) (Address)

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber's Relationship to Patient: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**If it should be necessary to initiate legal proceedings to collect any unpaid amount, I will be responsible for all collection fees plus all interest charges.**

Signed \_\_\_\_\_ Date \_\_\_\_\_