Patient Contact Information

Name: ____ ____ _______
LAST NAME FIRST NAME MI

Street Address: ______________________________ City: _____________________ State: ________ ZIP: _____________

Home Phone: ( ) _____________________ Cell Phone: ( ) ______________________

Primary Phone: ☐ Cell Phone ☐ Home Phone

Date of Birth ______/__________/___________ Age: _________ Social Security #: __________/__________/__________

Ethnicity: ___________________________________Language:_________________________ Do you need an interpreter? Yes No

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired Occupation: ___________________________________

Employer Name: ____ Employer Phone Number: ( ) ___________________________

Are you a student? Yes No

Marital Status

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse/Partner's Name: __________________________________

Email and Text Messages

Email Address: ______________________________________ Do you receive text messages? Yes No

Insurance Billing Information ☐ SELF PAY/CASH

PRIMARY Insurance Company Name: ________________________________

Insurance ID Number (Policy Number): ____________________ Group ID: _____________________

Name of Guarantor____Relationship _______________________

SECONDARY Insurance Company Name:______________________________________

Insurance ID Number (Policy Number): __________________________

Name of Guarantor____Relationship ________________________

Referral Information
How were you referred to us? ☐ Insurance Company ☐ Primary Care Physician ☐ Self Referred ☐ Zoc Doc ☐ Internet ☐ Mail/Flyer

Primary Care Physician / Family Doctor
Name____ City _____________________Phone Number____________________________

Emergency Contact Information
Emergency Contact Name: ______________________________________Relationship to Patient: ______________________________ Street Address: ___________________________________ City: _____________________ State: ________ ZIP: _____________ Home Phone: ( ) _________________ Work Phone: ( ) _____________________________Cell No.__________________

Pharmacy Information
Pharmacy Name: ________________________________ Street Address: ____ City: ___________________ Zip: ______________ Phone: ( ) _________________ Fax: ( ) _______________________

Consent to Examination • Authorization to Release Information • Assignment of Benefits • Financial Agreement

I hereby authorize the above physician to perform a consultation and examination, and to initiate diagnostic and therapeutic treatments that may be considered advisable or necessary. I hereby authorize the above physician to release to the insurance company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby give lifetime authorization for payment of insurance benefits to be made directly to the physician rendering service. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize these physicians to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Your Name: ____ Date: ____

Your Signature: ____ Date: ____