Today's Date _____ Date of Birth _____ Age today _____

Patient Name _____SSN#_____
First Middle Last

Address _____
Street City State Zip

Telephone Numbers _____
Home Work Cell

Email Address (optional)_____

Occupation _____ Place of Work _____

Work Address _____

Spouse/Parent _____ Contact Phone _____

Occupation _____ Business Phone _____

Business Address _____

Emergency Contact (other than spouse) _____
Name Relationship Phone Number

Referred by _____

Family Physician _____ Phone # _____

Financially Responsible Party (If other than above)_____

Address _____ Phone # _____

ALL PATIENTS OR AUTHORIZED PERSONS PLEASE SIGN:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS THIS CLAIM AND REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT:

Signed _____Date _____
Patient's or Authorized Person's Signature

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED.

Signed _____ Date _____
Insured or Authorized Person

INSURANCE (for non-cosmetic charges only) Please provide your insurance card(s) for photocopy.

Primary Insurance Carrier _____ ID#_____
Group #_____

Secondary Insurance Carrier _____ ID# _____
Group # _____