



Patient Information

Full Name: _____ Date: _____

Date of Birth: _____ Male Female Social Security #: _____

Address: _____
Street City State Zip

Hm Phone: () _____ Wk Phone: () _____

Email: _____

Marital Status: Single Married Widowed

Insurance Information

Name of Policy Holder: _____ Policy Holder's SS#: _____

Policy Holder's Date of Birth: _____ Employer: _____

Relationship to Policy Holder: Self Spouse Dependent

<input type="checkbox"/> Primary Insurance: _____ Group #: _____ ID#: _____	<input type="checkbox"/> Secondary Insurance: _____ Group #: _____ ID#: _____
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Who should we notify in case of emergency?

Name: _____ Relationship to patient: _____

Address: _____
Street City State Zip

Home Phone: () _____ Wk Phone: () _____

Financial Assignment & Agreement:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.
2. In order to control your cost of billings, we request that your charges for office visits be paid at the beginning of each visit unless you are covered by Medicare.
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services to the Health Care Financing Administration, its agents, or any insurance carrier I may have.
4. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
5. Be advised that there will be a \$25 service charge for NSF / Returned checks.

Patient Signature (or legal guardian if patient is a minor): _____ Date: _____