

Insurance Information/Authorization

Patient Information

Name _____ SSN _____ DOB _____

Address _____

(City) _____ (State) _____ (Zip) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____

Sex: Male ___ Female ___ Marital Status _____ Is the patient a student? _____

Spouse's Name _____ Spouse's phone _____

Emergency contact _____ Phone _____

Primary Physician _____ Phone _____

If patient is under 18 years old, please list parents' names:

Mother: _____ Father _____

Medical Insurance Information (Please give your card(s) to the front desk)

Primary Insurance Company Name _____

I.D. # _____ Group # _____

Insured's name _____ Insured's DOB _____

Insured's phone _____ Employer and address _____

Secondary Supplemental Medical Insurance Information _____

I.D. # _____ Group # _____

Insured's name _____ Insured's DOB _____

Insured's phone _____ Employer and address _____

May we contact you by Mail? YES NO

What is your reason for today's visit? _____

How did you hear about us? _____

Would you like a copy of your report sent to your primary care physician? _____

Assignment of Insurance Benefits

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance carriers.
- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- I authorize payment to my doctor.
- I permit a copy of this authorization to be used in the place of the original.

Name (Please Print) _____

Signature _____ Date _____