PLEASE COMPLETE ALL INFO BEFORE RETURNING

NAME: Last_____ First_____ Middle Initial_____
ADDRESS: _____ City_____ ST_____ Zip_____
PHONE Home ( )_____ Work ( ) _____ Cell ( )_____

May we leave a message? Y/N **Which number do you prefer?** Home Work Cell

Marital Status: S M D W **Date of Birth:** _____ **Sex:** M / F
Employer_____ Occupation_____
Family Dr._____ Phone_____
Referred by_____ Phone_____

Minors:
Parents/ Guardian's Name_____ Phone_____
Address_____

INSURANCE INFORMATION: REQUIRED REGARDLESS OF COPY TAKEN
1ST Insurance_____ Name of Insured_____ Birth Date_____
Employer_____ Relationship to insured: SELF SPOUSE CHILD
I.D# _____ Group#_____ Referral? **Y/ N** Copay_____

2nd Insurance_____ Name of Insured_____ Birth Date_____
Employer_____ Relationship to insured: SELF SPOUSE CHILD
I.D# _____ Group#_____ Referral? **Y/ N** Copay_____

OTHER THAN A PHYSICIAN, who can we release your medical information to?
Print Name: _____ **Relationship**_____ **Phone**_____

I hereby authorize treatment of the above patient. I acknowledge full responsibility for the payment of services rendered. I understand and agree that medical insurance is an arrangement between the insurance carrier and the patient. I also authorize Dr. Banki/Justyna Pachowska, PA-C to release any medical information necessary to process the claim(s).

Signature: _____ **Date:** _____

I authorize payment of medical benefits by my secondary carrier to Dr. Banki/Justyna Pachowska, PA-C for services provided.

Signature: _____ **Date:** _____