**Who referred you to our office?**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Primary Physician: (First Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, M.D. / D.O. | | | | | | | |
| Patient Information | Email Address | | Patient Name | | | | | Social Security # |
|
| Date of Birth | Sex | Marital Status- Single, Married,Widowed,Divorced | | | Relationship to Guarantor | | Previous Name if Changed |
|
| Race | | Ethnicity | | | | Primary Language | |
|
| Address | | | | | | City, State, Zip | |
|
| Home Telephone | | | | Cell or Pager # | | | |
|
| Employer and Address | | | | | | Work Telephone | |
|
| Preferred Pharmacy, Phone Number and Street Address | | | | | | | |
|
| Guarantor Information | Responsible or Custodial Parent | | | Guarantor Name | | | | Social Security # |
|
| Date of Birth | Sex | | Relationship of patient to guarantor | | | | Home Telephone |
|
| Guarantor Address | | | | | | | |
|
| Guarantor Employer | | | | | | Work Telephone | |
|
| Employer Address | | | | | | | |
|
| Emergency Contact | Contact Name | | | | | Relationship to Patient | | |
|
| Home Telephone | | | | | Work Telephone | | |
|
| Spouse or Parent | Name | | | | | | Home Telephone | |
|
| Address | | | | | | | |
|
| Employer | | | | | | Work Telephone | |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Insurance | Primary Insurance Company Name | | | Telephone Number |
|
| Address | | | |
|
| Group Number | Policy Number | Effective Date | Relationship to Subscriber |
|
| Subscriber's Name | | Subscriber's Employer | |
|
| Secondary Insurance Company Name | | | Telephone Number |
|
| Address | | | |
|
| Group Number | Policy Number | Effective Date | Relationship to Subscriber |
|
| Subscriber's Name | | Subscriber's Employer | |
|

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional service rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I authorize the staff to perform all necessary services needed during diagnosis and treatment. I also authorize the provider to release all information required to process insurance claims.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if over 18 years of age)