

**PATIENT INFORMATION**

FIRST NAME \_\_\_\_\_  
 LAST NAME \_\_\_\_\_  MID INITIAL \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_  
 WORK/CELL PHONE \_\_\_\_\_  
 AGE \_\_\_\_\_  DATE OF BIRTH \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 SEX M / F / T MARITAL STATUS S M W D SEPERATED  
 E-MAIL ADDRESS \_\_\_\_\_

**Preferred Method of Communication**

E-mail  Cell Phone  Home Phone  Work Phone  Decline  
 EMPLOYER \_\_\_\_\_  
 PRIMARY CARE PHYSICIAN \_\_\_\_\_  
 REFERRED BY \_\_\_\_\_

*Please circle one of the following*

ETHNICITY:  
Hispanic /Latino    Non- Hispanic /Latino    Decline to Answer  
 RACE:  
Am. Indian/Alsaka Native    Asian    Black or African American  
Native Hawaiian / Other Pacific Islander    White    Decline to Answer

PREFERRED LANGUAGE: \_\_\_\_\_

SMOKING STATUS: (Circle) Yes No

If yes, how many a day? \_\_\_\_\_  
Are you a Former Smoker? Yes No Date you quit? \_\_\_\_\_

**PARENT or SPOUSE** (Must complete if Insurance is through a parent or spouse.)

NAME \_\_\_\_\_  
 RELATIONSHIP \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 CELL PHONE \_\_\_\_\_  
 WORK PHONE \_\_\_\_\_  
 SOCIAL SECURITY # \_\_\_\_\_  
(Must complete if Insurance is through a parent or spouse.)  
 DATE OF BIRTH \_\_\_\_\_  SEX (Circle) Male Female  
 EMPLOYER \_\_\_\_\_

**IN CASE OF AN EMERGENCY OR NEXT OF KIN**

Please Provide Address if different than patient.

NAME \_\_\_\_\_  
 RELATIONSHIP \_\_\_\_\_

PHONE # \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**INSURANCE INFORMATION**

*Please be sure to fill out your order of insurances and insurance information accurately in order to not be billed incorrectly.*

I am insured through: (Circle) SELF JOB SPOUSE PARENT

**PRIMARY INSURANCE**

Insurance Company Name \_\_\_\_\_  
 Name on Primary Insurance Card \_\_\_\_\_  
 ID# (Subscriber or member #) \_\_\_\_\_  
 GROUP # \_\_\_\_\_  
 Specialist Copay \_\_\_\_\_ Effective Date \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Company Name \_\_\_\_\_  
 Name on Secondary Insurance Card \_\_\_\_\_  
ID# (Subscriber or member #) \_\_\_\_\_  
 GROUP# \_\_\_\_\_  
 Specialist Copay \_\_\_\_\_ Effective Date \_\_\_\_\_

**TERTIRAY INSURANCE**

Insurance Company Name \_\_\_\_\_  
 Name on Secondary Insurance Card \_\_\_\_\_  
ID# (Subscriber or member #) \_\_\_\_\_  
 GROUP# \_\_\_\_\_  
 Specialist Copay \_\_\_\_\_ Effective Date \_\_\_\_\_

**RELEASE OF INFORMATION:**

( ) YES ( ) NO

I hereby authorize release of information for insurance claim purposes, transfer of care from one facility to the my current facility or vice versa, release for personal, family, work or other information. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV/Aids and Zika.

**I understand all of the above and hereby state that the information is correct to the best of my knowledge. After 45 days any balance not paid or denied by insurance becomes the patient balance and due immediately. If my delinquent balance gets turned over to an outside collections agency I understand a billing fee of 35% will be added to my current balance.**

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Responsible Person or Parent/Guardian if minor)