Patient Demographics

Last Name _____ First Name _____ MI ____
DOB ___/___/___ SSN _____ Marital Status S ___ M ___ D ___ W ___ M/F
Cell # _____ Home # _____ Race _____
Email _____
Address _____
City _____ State _____ Zip _____
Employer _____ Phone _____
Address _____
Family Physician _____ Phone _____

Parent/Spouse/Guardian – Circle One if Applicable

Last Name _____ First Name _____ MI _____
Home # _____ Cell _____
DOB ___/___/___ SSN ____-____-____ M / F Email _____
Address _____
City _____ State _____ Zip _____

Emergency Contact

Name _____ Phone _____

Insurance

Primary _____ Secondary _____
Name of Insured _____ Name of Insured _____
DOB ___/___/___ SSN ____-____-____ DOB ___/___/___ SSN ____-____-____
Policy# _____ Policy # _____
Group # _____ Group # _____
Claim Address _____ Claim Address _____
_____ _____
Ins. Phone _____ Ins. Phone _____

I authorize the release of any information necessary to process the insurance claim. I understand that I am financially responsible for this account regardless of insurance coverage and for payment of any amount not covered by my insurance company. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on a defaulted account.

_____ _____
Signature **Date**