

Welcome to our Practice!

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In order to file your insurance and serve you properly we will need the following information. (please print)

Patient's Name	Birthdate	Age	Sex Male U Female U	Marital Status Single U Divorced U Married U Widowed U
Street	City	State	Zip	
Residence Address:				
Home Telephone: ()			Employer	
Business Telephone: ()			Business Address	
Social Security number:			E-Mail Address (if available)	
Referring Doctor:			Referring Doctor phone number ()	
If patient is a child, parent's name or guardian's name:				

INSURANCE INFORMATION

Name of Insured:	Birthdate	Relationship to Patient
Employer:	Business Address:	
Business Telephone: ()	Social security number of Insured	
Name of Insurance: (PRIMARY)		Insurance tel. Number
ID#:	GROUP/PLAN#:	
Name of Insurance: (SECONDARY)		Insurance tel. Number
ID#:	GROUP/PLAN#:	
WORKER'S COMPENSATION:		
Name of Company:	Address:	
Company phone: ()	Treatment Authorized By:	
Emergency Contact:		
Name:	Relationship:	Tel. Number: ()
Reason for appointment/Chief Complaint:		

I authorize the release of any medical or other information necessary to process my insurance claims.

Patient, Parent, or Guardian Signature _____ **Date:** _____

I authorize payment of medical benefits to the physician. I understand I am financially responsible for all charges not reimbursed by my insurance company. I also understand verification of insurance is not a guarantee of payment. Reimbursement is determined when the claim is submitted.

Patient, Parent, or Guardian Signature _____ **Date:** _____