PATIENT INFORMATION: Please Print

Last Name: _________________________First Name: ____________________ Middle Initial: ___

Address: ___________________________ City: ____________________ State: _____ Zip: ________

Preferred Phone #: _____________________________ Date of Birth: _______________

Employment & Address: _______________________City: _______________ State: ______

Emergency contact name: _______________________ Phone number: _________________

Who referred you? _____________________________

RESPONSIBLE PARTY INFORMATION:

Last Name: _________________________First Name: ____________________ Middle Initial: ____

Address: ___________________________ City: ____________________ State: _____ Zip: ________

Preferred Phone #: ______________________________Date of Birth: ________________

Relationship to the patient: ______________________________

PRIMARY CARE DOCTOR:

Doctor: ______________________________ Name of Practice: ______________________________

Address: ____ Phone: __________________

PRIMARY INSURANCE INFORMATION:

Insurance company: __________________________________ ID Number of patient: ______________

Company Address: ___________________________________

Insured parties name: ______________________________Phone number:__________________

Insured address: ___________________________City: _____________ State ______ Zip:_________

Social Security Number: ____________________ Date of birth: ______________

I authorize payment directly to the provider, realizing that I am responsible for payment of non-covered services including copayments. I authorize the provider to release any information acquired during treatment necessary to process claims.

Signature: ____Date: _________________________