



Patient Contact Information

Name: _____
LAST NAME _____ FIRST NAME _____ MI _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: () _____ Cell Phone: () _____

Primary Phone: Cell Phone Home Phone

Date of Birth _____ / _____ / _____ Age: _____ Social Security #: _____ / _____ / _____

Ethnicity: _____ Language: _____ Do you need an interpreter? Yes _____ No _____

Employed Unemployed Disabled Retired Occupation: _____

Employer Name: _____ Employer Phone Number: () _____

Are you a student? Yes _____ No _____

Marital Status

Marital Status: Single Married Divorced Widowed Spouse/Partner's Name: _____

Email and Text Messages

Email Address: _____ Do you receive text messages? Yes _____ No _____

Insurance Billing Information

SELF PAY/CASH

PRIMARY Insurance Company Name: _____

Insurance ID Number (Policy Number): _____ Group ID: _____

Name of Guarantor _____ Relationship _____

SECONDARY Insurance Company Name: _____

Insurance ID Number (Policy Number): _____

Name of Guarantor _____ Relationship _____



Referral Information

How were you referred to us? Insurance Company Primary Care Physician Self Referred Zoc Doc
 Internet Mail/Flyer

Primary Care Physician / Family Doctor

Name _____ City _____ Phone Number _____

Emergency Contact Information

Emergency Contact Name: _____ Relationship to Patient: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: () _____ Work Phone: () _____ Cell No. _____

Pharmacy Information

Pharmacy Name: _____ Street Address: _____

City: _____ Zip: _____ Phone: () _____ Fax: () _____

Consent to Examination • Authorization to Release Information • Assignment of Benefits • Financial Agreement

I hereby authorize the above physician to perform a consultation and examination, and to initiate diagnostic and therapeutic treatments that may be considered advisable or necessary. I hereby authorize the above physician to release to the insurance company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby give lifetime authorization for payment of insurance benefits to be made directly to the physician rendering service. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize these physicians to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Your Name: _____ Date: _____

Your Signature: _____ Date: _____