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Patient's Name: _____
First Name Last Name Middle Social Security Number

Address: _____
Street City State Zip

Date of Birth: ____/____/____ Marital Status: S M W D Sep
Month Date Year

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referred by: _____ Family Dr.: _____

Employer Name: _____ Occupation: _____

Spouse's Name: _____ Home #: _____ Work #: _____ Cell #: _____

Emergency Contact: _____ Phone #: _____ Relation: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Other: _____

Insured Person (If other than patient)

Name: _____
First Name Last Name Middle Social Security Number

Date of birth: ____/____/____ Relationship: _____ Phone #: _____
Month Date Year

Employer Name: _____ Phone #: _____

AUTHORIZATION / PROMISSORY NOTE

- I authorize my doctor to bill my insurances for all services rendered and release any required information.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance coverage.
- I understand that I am financially responsible for all charges regardless of insurance coverage.
- I promise to pay any co-pay, deductible, coinsurance, or any patient liability not covered by insurance.
- I authorize payment of the medical benefits directly to the doctor for services rendered.
- I permit a copy of this authorization to be used in place of the original.
- I understand that I am responsible for obtaining any referrals that are needed.

Patient/Guarantor Signature: _____ Date: ____/____/____
Month Date Year