Welcome to our practice. Please complete this form to help us serve you better

Patient Name _____ Nickname / Preferred Name _____

Date of Birth _____

Check all of the following that apply please:

__ male __ female __married __divorced/ separated __ minor __single __ widowed/widower

Address _____ Mailing Address (if different) _____

City _____ City_____

State _____Zip_____ State & Zip_____

Employer _____ Occupation _____

Referred By (how did you hear about us): _____

Contact Information

Home Phone _____ Cell _____ Work _____

Who would you like us to contact in the event of an emergency? _____

We will be happy to copy your card(s) if you prefer

(remember we will still need the insured's birth date please)

Primary Insurance Secondary Insurance

Name of Insured _____ Name of Insured _____

Insured's Birth Date _____ Insured's Birth Date _____

Insurance Carrier _____Insurance Carrier _____

Policy Number _____ Policy Number _____

Group Number _____ Group Number _____

Plan Number _____ Plan Number _____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment and examination rendered to me (or my child) during the period of such care to third party payers.

I authorize and request my insurance carrier to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the entirety of the bill for services. I agree to be responsible for payment of all services rendered on my behalf (or my dependent's behalf).

_____ _____

Signature of patient (or parent/guardian) Date