PLEASE PRINT DATE_____

Name_____
First MI Last

Home Address_____

City_____ State ____Zip_____ Home Phone#_____

Daytime Phone# _____E-mail_____

May we contact you by e-mail? Y N

Date of Birth_____ Social Security #_____

Male Female Nickname _____

Person responsible for payment_____

Father (or legal guardian) Name and Phone #_____

Address if Different_____

Employer Name and Phone #_____

Date of Birth_____ Social Security #_____

Mother (or legal guardian) Name and Phone #_____

Address if Different_____

Employer Name and Phone#_____

Date of Birth_____ Social Security #_____

Primary Insurance_____

Secondary Insurance_____

Medicaid #_____

Please read and sign below.

I authorize the release of any medical or other information necessary to process claims under my insurance. I authorize payment of covered benefits to be made to the doctor, however, I agree to be fully responsible for all lawful debts incurred not paid by my insurance.

Signature_____ Date_____