PLEASE PRINT DATE_____

Mr. Mrs. Ms. Miss Dr.

Name_____
First Middle Last

Home Address_____

City_____ State ____Zip_____ Cell #_____

Work Phone #_____ Home #_____

E-mail_____

May we contact you by e-mail? **Y** **N** text? **Y** **N**
Nickname_____

Date of Birth_____ Social Security #_____

Employer _____Occupation_____

Marital Status: single married separated divorced widowed

Spouse's Name_____ Date of Birth_____

Employer_____ Social Security #_____

Person responsible for payment_____

Primary Insurance_____

Secondary Insurance_____

Medicaid #_____ Medicare #_____

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_____