Patient Information

LAST NAME_____________________________________ FIRST NAME____________________________

DATE OF BIRTH____/_____/______ SEX: M F (Circle one)

HOME ADDRESS ____Apt #_______

CITY ________________________STATE_______ ZIP __________

HOME TELEPHONE #: (____)_________________WORK TELEPHONE # (____)____________________

EMERGENCY CONTACT ____ TEL #:____________________

PRIMARY INSURANCE COMPANY: (WHO DO WE BILL?):

____

YOUR POLICY #:_______________________________

POLICY HOLDER (IF NOT YOU) Last Name___________________________First Name________________

LIST ALL SECONDARY INSURANCES____

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NOTICE OF ADVICE: THE TREATMENT MAY NOT BE COVERED BY THE PATIENT'S HEALTH CARE PLAN OR INSURER WITHOUT A REFERRAL AND THAT SUCH TREATMENT MAY BE A COVERED EXPENSE IF RENDERED PURSUANT TO A REFERRAL

I, THE UNDERSIGNED, AGREE TO BE TREATED IN THE HOME AND HEREBY AUTHORIZE MY INSURANCE CARRIER TO PAY THE PROVIDER DIRECTLY FOR SERVICES RENDERED. I HAVE READ THE ABOVE AND AGREE TO COMPLY FULLY, SIGNED:

SIGNATURE____TODAYS DATE____/_____/______

HOW DID YOU FIND OUR PRACTICE? ____