

Patient Information

Name: MR. MRS. MISS MS.		FIRST	MIDDLE	LAST	Today's Date:
Home Phone:			Social Security #: - -		
Work Phone:			Birth Date: / /		Age:
Cell / Pager / Other:			Gender: M F		Marital Status: Single Divorced Married Widowed
E-Mail:			Occupation:		
Address:		Apt.		Employer:	
City:	State:	Zip:			
Emergency Contact:			Special Needs:		
Phone:			<input type="checkbox"/> Hearing-impaired <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Other: _____ <input type="checkbox"/> Translator Language: _____		
Relationship to patient:					
PRIMARY Insurance:			<i>Patient is the policy subscriber / guarantor:</i>		
ID / Policy #:			<input type="checkbox"/> Yes <input type="checkbox"/> No		
SECONDARY Insurance:					
ID / Policy #:			<input type="checkbox"/> Yes <input type="checkbox"/> No		
VISION / OPTICAL Insurance:			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If policy subscriber / guarantor is other than the patient:</i>					
Name:			Social Security #: - -		
Phone:			Birth Date: / /		
Relationship to patient:			Employer:		
Family / Primary Physician:			Phone:		
Address:					
Pharmacy:			Phone:		
Address:					

- I acknowledge receipt of the "Summary of Privacy Practices" (rev. September 23, 2013) and understand that I may request to review the full-length "Notice of Privacy Practices" (rev. September 2013). _____ (initial)
- I authorize the release of any medical information necessary to process all claims. I also authorize the release of payment of medical benefits to my physician. If my insurance denies the claims, I agree to be financially responsible for my bill, and I have read and understand the "Statement of Patient Financial Responsibility" provided to me. _____ (initial)

Patient Signature: _____ **Date:** _____