

**PATIENT INFORMATION**

(PLEASE PRINT)

NAME		DATE		
ADDRESS		CITY	ZIP	
HOME PHONE	BUSINESS PHONE	SOCIAL SEC. NO.		
DATE OF BIRTH	AGE	SEX M F	MARITAL STATUS	S M W D SEP.
REFERRED BY	PERSONAL PHYSICIAN			
PATIENT'S EMPLOYER	POSITION			
BUSINESS ADDRESS				
SPOUSE'S NAME	SPOUSE'S EMPLOYER	SPOUSE'S BIRTHDATE:		

**PERSON RESPONSIBLE FOR BILL**  
(IF OTHER THAN ABOVE)

NAME	RELATIONSHIP
ADDRESS (IF OTHER THAN ABOVE)	HOME PHONE
EMPLOYER	POSITION
BUSINESS ADDRESS	BUSINESS PHONE

**INSURANCE, MEDICARE, WORKER'S COMPENSATION or WELFARE INFORMATION**

COMPANY OR PROGRAM	INSURED SS#	GROUP NUMBER	POLICY NUMBER
1.			
2.			

**NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY**  
(IF NOT ALREADY LISTED)

NAME	RELATIONSHIP
ADDRESS	HOME PHONE
EMPLOYER	BUSINESS PHONE
POSITION	

**AUTHORIZATIONS**

**BENEFITS TO PHYSICIAN:**

- Yes  No I hereby authorize payments directly to the physician of the surgical and/or medical benefits.  
 Yes  No I also understand I am responsible for any portion of my bill not covered by my insurance company.

**RELEASE OF INFORMATION:**

I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES.

- Yes  No The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhoea, HIV and AIDS.

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Date \_\_\_\_\_

Signed \_\_\_\_\_

(Insured Person)