PATIENT INFORMATION (Please print)

Name _____ Date _____
Address _____
City _____ State _____ Zip _____ SS # _____
Home phone _____ Cell phone _____ Work phone _____
Email address _____
Date of birth _____ Age _____ Sex: F M Martial Status: S M W D
Referred by _____ Personal physician _____
Employer _____ Position _____
Address _____
Spouses name _____ Employer _____ Date of birth _____

PERSON RESPONSIBLE FOR BILL (if other than above)

Name _____ Relationship _____
Address _____
Home phone _____ Cell phone _____ Work phone _____
Address _____

INSURANCE

Primary insurance _____ ID # _____ Group # _____
Secondary insurance _____ ID # _____ Group # _____

EMERGENCY CONTACT

Name _____ Relationship _____
Address _____
Home phone _____ Cell phone _____ Work phone _____

AUTHORIZATIONS

_____ I hereby request medical treatment and authorize payment to Dr. Gardner.
_____ I also understand I am responsible for any portion of my bill not covered by my insurance company.
_____ I hereby authorize the release of medical information for insurance claim purposes.

Date _____ Signature _____