PATIENT INFORMATION

PATIENT NAME	DOB	PRIMARY CARE PHYSICIAN
STREET ADDRESS	APPT#	HOME PHONE #
CITY	STATE/ZIP	
	SEX M F	SOC. SEC.#
SCHOOL NAME	EMPLOYMENT STATUS N/A STUDENT EMPLOYED	
MOTHER'S NAME	DOB	PHONE #
FATHER'S NAME	DOB	PHONE #
GRANDPARENT'S NAME		PHONE #
EMERGENCY CONTACT/NAME	PHONE #	RELATIONSHIP

GUARANTOR INFORMATION

GUARANTOR (IF OTHER THAN PATIENT)			RELATIONSHIP
GUARANTOR'S BIRTHDATE			SOC. SEC. #
GUARANTOR'S ADDRESS			HOME PHONE #
CITY	STATE	ZIP	WORK PHONE #
EMPLOYER/SCHOOL NAME			

INSURANCE - please present insurance information to the receptionist

PRIMARY INSURANCE NAME		INSURANCE ID #
PHONE #		INSURANCE GROUP #
INSURED'S NAME	DOB	INSURED'S EMPLOYER
ADDRESS	CITY/STATE/ZIP	
SECONDARY INSURANCE NAME		INSURANCE ID #
PHONE #		INSURANCE GROUP #
INSURED'S NAME	DOB	INSURED'S EMPLOYER
ADDRESS	CITY/STATE/ZIP	

I hereby authorize treatment and authorize the provider of medical services to release information for services to my insurance carrier for payment. I authorize payments of benefits be made to the provider on my behalf and understand my responsibility for all charges not covered by insurance.

I also authorize and give permission to the attending physician, and other health professionals associated with my physician, to discuss medical or other relevant information with our physician's legal counsel, accountant, medical malpractice carrier, or billing and coding agents as may be deemed necessary by our physician. A copy of this authorization shall be considered as valid as the original.

SIGNATURE　　　　DATE