**PLEASE PRINT CLEARLY**

Name _____ Soc Sec#_____

Address _____ City _____ State _____ Zip_____

Phone Home_____ Work _____ Cellular _____

Date of Birth _____ Age _____ Sex M / F Marital Status _____

Occupation _____

Employer Name and Address _____

_____

Primary Care Physician _____ Phone _____

May our office leave a message on your answering machine ( ) Home ( ) Work ( ) Cell
(PATHOLOGY AND LAB RESULTS WILL NOT BE LEFT ON THE ANSWERING MACHINE)

If you wish to receive office communications via email, please leave your address below.
EMAIL ADDRESS _____

If unable to reach you, who, if anyone, may we release medical and/or billing information to?
Name _____ Relationship _____ Phone_____

**INSURANCE INFORMATION**

Primary Insurance Company _____

Insurance Co Address _____

ID# _____ Group # _____

Policy Holder _____ Relationship to patient _____

Birthdate _____ Soc Sec # _____ Effective Date _____

Name of Employer _____ Work Phone_____

Secondary Insurance Company _____

Insurance Co Address _____

ID# _____ Group # _____

Policy Holder _____ Relationship to patient _____

Birthdate _____ Soc Sec # _____ Effective Date _____

Name of Employer _____ Work Phone_____

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the undersigned physician or supplier for services performed. Health insurance will only pay for services which are considered "reasonable and medically necessary." If the carrier determines that a service is non-covered, I understand that I am financially responsible for all charges for services performed.

X _____ _____
Signature of patient or parent/guardian Date

*****PLEASE BRING INSURANCE CARDS TO FRONT DESK WITH THESE FORMS*****