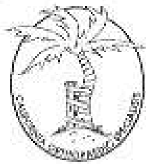

Account #:

| PATIENT INFORMATION | |
|---|---|
| Name: | Date of Birth: |
| Street Address: | Social Security #: |
| City: | Sex: |
| State: Zip: | Emergency Contact Info |
| Home Phone#: | |
| Work Phone#: | Emergency Contact: |
| Cell Phone#: | Emergency Phone#: |
| Email: | Emergency Relationship: |
| **GUARANTOR INFORMATION** | |
| Name: | Date of Birth: |
| Address One: | Social Security#: |
| Address Two: | |
| City: | Employer: |
| State: Zip: | Employer Address: |
| Home Phone#: | Employer City: |
| Work Phone#: | Employer State: Zip: |
| Cell Phone#: | |
| **INSURANCE INFORMATION** | |
| Primary Insurance: | Secondary Insurance: |
| Certificate#: | Certificate#: |
| Group Number: | Group Number: |
| Group Name: | Group Name: |
| Copay: $ | Copay: |
| Subscriber Name: | Subscriber Name: |

1. I hereby assign the insurance benefit payment, both basic and major medical to which I am entitled, directly to the doctor rendering service. I understand that I am financially responsible for the charges not covered by the assignment. A photocopy of this authorization is accepted with the same authority as the original.
2. I hereby authorize the physician to release any information acquired in the course of my treatment to another physician of my choice, my insurance company, my attorney or to me at my above address, within 1 year of the date of this signature.

Date _______________ Signature (Guaridan/Parent if patient is a minor) _______________

Witness _______________ Relationship to Patient _______________