



### PATIENT INFORMATION

DATE: \_\_\_/\_\_\_/\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ HOME ADDRESS \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
LAST NAME \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
MARITAL STATUS     MARRIED     SINGLE    WORK PHONE \_\_\_\_\_  
                           DIVORCED     WIDOWED    CELL PHONE \_\_\_\_\_  
(CHECK ONE)     EMPLOYED     RETIRED     FULL TIME STUDENT  
EMPLOYER \_\_\_\_\_ PRIMARY DOCTOR \_\_\_\_\_  
REASON FOR TODAY'S VISIT \_\_\_\_\_

### INSURANCE INFORMATION

**PLEASE PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK**

COMMERCIAL     MEDICARE     MEDI-CAL     WORKERS COMPENSATION     OTHER \_\_\_\_\_  
PRIMARY INSURANCE COMPANY \_\_\_\_\_  
SUBSCRIBER'S NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
MEMBER ID# \_\_\_\_\_ GROUP# \_\_\_\_\_  
SECONDARY INSURANCE COMPANY \_\_\_\_\_  
SUBSCRIBER'S NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
MEMBER ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

### EMERGENCY CONTACT

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

#### AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to the Physician of the medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

#### AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process claims.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_