Medical Insurance Information

Patient _____ DOB ___/___/_____ Age ____ Sex ____
Last First

Social Security # ____-___-_____ Phone (____)_____ Marital Status _____

Home Address _____
Street City State ZIP

Employer _____ Occupation _____

Employer Address _____
Street City State ZIP

Parent, Spouse, or Reponsible Party _____
Name Relationship

Contact Information _____
Address Phone

Emergency Contact _____
Name Address Phone

Referred by _____
Name Address Phone

Are you presently a member of an HMO health plan? YES NO (please circle)

Primary Insurance:
Insurance Company _____ Group/Policy #_____

Policy Holder _____ Member/ ID # _____

Date of Birth __/__/____ Sex ____ Patient Relationship to Policy Holder _____

Primary Care Physician _____ Referring Medical Group _____

Secondary Insurance:
Insurance Company _____ Group/Policy #_____

Policy Holder _____ Member/ ID # _____

Date of Birth __/__/____ Sex ____ Patient Relationship to Policy Holder _____

Primary Care Physician _____ Referring Medical Group _____

_____

Consent for use and disclosure of protected health information

By signing below, you consent to the use and disclosure of your protected health information by our office for treatment, payment, and health care operations. For a more detailed explanation, please review our Notice of Information Practices posted at the front desk.

Patient or Guardian's Signature _____ Date _____