

**WELCOME TO OUR OFFICE**

Patient Information as of \_\_\_\_\_ (enter today's date)  
(Please Print Legibly & Fill In or Correct All Fields)

**Patient's Name** \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street & Apt # City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**E-mail** \_\_\_\_\_ Would you like emails about upcoming specials/events?  No  Yes

Patient's Employer \_\_\_\_\_ Full/Part/Student work?  Yes  No  
Is it okay to call you at \_\_\_\_\_

**Age** \_\_\_\_\_ **Birthdate** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **SS#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **Sex**  Female  Male

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

**Responsible Party Name**  
(If patient is a child)

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Emergency Contact**  
(Not in your household)

Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**\*Whom may we thank for referring you?** \_\_\_\_\_

**\*Only fill out this section if you are using insurance\*↓**

**Primary Health Insurance Company**

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Copay?  No  Yes, \$ \_\_\_\_\_

Policyholder \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relation to patient \_\_\_\_\_

**Secondary Health Insurance Company  
or Workers Compensation**

Policy # or Claim # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Copay?  No  Yes, \$ \_\_\_\_\_

Policyholder \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relation to patient \_\_\_\_\_

I hereby authorize release of information for insurance claim purposes.

**BENEFITS TO PHYSICIAN:** I hereby authorize insurance payments to the physician of the surgical and or medical benefits. I understand the office will preauthorize my surgery as a courtesy. **I have been notified that preauthorization is not a guarantee of payment and accept responsibility of any unpaid amount.**

**I understand all the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of the authorization and also agree to honor billing policies as outlined in the treatment, payment and health care operation consent.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_