



## Patient Information Form

Due to the excessive amount of information required for the specialist's office to process and submit a claim, please complete ALL PORTIONS of this form. It is crucial that you supply us with your most current and up-to-date insurance information. You will be asked to update information at a minimum on an annual basis. Your patience and diligence is very much appreciated.

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

**Address:** \_\_\_\_\_  
Street & Apt # City State Zip Code

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Other Phone:** \_\_\_\_\_  
**Email:** \_\_\_\_\_ **Receive Emails on Promotions and Announcements**  Yes  No

**Gender:**  Female  Male **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **SS#:** \_\_\_\_\_  
**Marital Status:**  Single  Married

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Who Referred You?** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_  
**Home Phone #:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_ **Other:** \_\_\_\_\_

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| <p><b>Primary Insurance Company (Name):</b> _____<br/>Policy #: _____ Group #: _____ Insurance Phone #: _____<br/>Referral Required? <input type="checkbox"/> No <input type="checkbox"/> Yes<br/>Name of Policy Holder: _____ Policy Holder Birth Date: _____<br/>Policy Holder SS#: _____<br/>Patient Relationship to Insured Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child or Dependent <input type="checkbox"/> Other _____</p> |
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| <p><b>Secondary Insurance Company (Name):</b> _____<br/>Policy #: _____ Group #: _____ Insurance Phone #: _____<br/>Referral Required? <input type="checkbox"/> No <input type="checkbox"/> Yes<br/>Name of Policy Holder: _____ Policy Holder Birth Date: _____<br/>Policy Holder SS#: _____<br/>Patient Relationship to Insured Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child or Dependent <input type="checkbox"/> Other _____</p> |
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| <p><b>Guarantor Information (Name):</b> _____<br/>Name of Guarantor: _____ Guarantor Birth Date: _____<br/>Guarantor Address: _____<br/>Guarantor Phone #: _____ Guarantor Email: _____<br/>Guarantor SS#: _____<br/>Patient Relationship to Insured Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child or Dependent <input type="checkbox"/> Other _____</p> |
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| <p style="text-align: center;"><b>Consent for Examination and Treatment</b></p> <p>I am at least 18 years of age, or, if not I am accompanied by a legal guardian or parent. I hereby consent to and authorize an examination by my doctor and such assistant or staff as may be assigned by him/her. If appropriate, I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I understand it is my responsibility to provide accurate and up to date insurance information prior to treatment.</p> <p><b>Signature of Patient or Parent/Guardian:</b> _____ <b>Date:</b> _____</p> |
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