



First _____ (MI) _____ Last _____ DOB _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Gender _____ SS# _____
 Employer _____ Occupation _____ Cell phone _____
 Employer Address _____ City _____ State _____ Zip _____
 Marital Status _____ Spouse Name _____ DOB _____
 Employer _____ Employer Phone _____
 Emergency Contact _____ Relation _____ Phone _____

COPAY AND DEDUCTIBLE PAYMENTS ARE REQUIRED AT TIME OF SERVICE

YOU WILL BE RESPONSIBLE FOR ANY BALANCE NOT COVERED BY YOUR INSURANCE.

SELF PAY PATIENTS WILL BE REQUIRED TO PAY FOR THEIR VISIT IN FULL AT THE TIME OF SERVICE

Commercial Insurance Notice

I hereby authorize the release of any information necessary to file a claim with my insurance and assign benefits to my physician indicated on the claims submitted.

 Patient Name Date

A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL

SIGNATURE OF PATIENT OR AUTHORIZED PERSON **DATE**