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PATIENT'S NAME _____ DATE OF BIRTH _____
AGE _____ SEX (M) (F) SOCIAL SECURITY (if required) _____
EMAIL _____
NAME OF PARENT (IF APPLICABLE) _____
NAME OF PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT THAN PATIENT)

_____
MAILING ADDRESS _____ CITY STATE, ZIP _____
CELL PHONE _____ HOME PHONE _____
BUSINESS PHONE _____ EMPLOYER _____

FINANCIALLY RESPONSILBE PERSON _____
DRIVERS LICENCE # & STATE _____
PRIMARY INSURANCE _____ SECONDARY _____
NAME OF INSURED _____ DOB_____
SSN (if required) _____
MAY WE LEAVE A MESSAGE ON YOUR CELL PHONE (Y) (N)
LIST PERSONS WITH WHOM WE CAN DISCUSS YOUR MEDICAL INFORMATION (WE CANNOT BE RELEASE INFORMATION TO ANYONE NOT LISTED ON THIS FORM)
1_____
2 _____
3 _____
EMERGENCY CONTACT RELATIONSHIP (spouse, sibling, etc.) _____
CELL PHONE _____
REFERRING PHYSICIAN _____
PRIMARY CARE PHYSICIAN (if different from referring)

_____

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY REFERRING DOCTOR/PRIMARY CARE PROVIDER AND ANY DOCTOR THAT I MAY BE REFERRED TO. I AUTHORIZE MY REFERRING DOCTOR TO RELEASE MY MEDICAL RECORDS. I AUTHORIZE THE RELEASE OF MEDICAL RECORDS NEEDED TO PROCESSS INSURNACE CLAIMS. I AFFIRM ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND ACCEPT FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED.

AUTHORIZED SIGNATURE_____
RELATIONSHIP TO PATIENT_____