DATE _____

PATIENT OR GUARDIAN NAME (if patient is minor) _____

Student: Full____ Part____

PATIENT'S NAME _____ *MALE__ FEMALE__ S.S.#*_____

Date of Birth _____ *Single__ Married___ Divorced___ Widowed___Seperated___*

Address _____ *City*_____ *St*_____ *Zip*_____

Telephone _____ *Work*_____ *Cell*_____

*Email*_____*Referred by* _____

*Emergency Contact*_____ *Ph#*_____

INSURANCE INFORMATION

INSURANCE CO _____ *PPO__HMO__ Ph#*_____

INSURED'S NAME _____ *Date of Birth* _____

POLICY # _____*GROUP*_____ *EFF*_____

*RELATIONSHIP TO PATIENT*_____ *EMPLOYER*_____

FOR OFFICE USE ONLY

Dr. _____

Is Provider participating? Yes___ No___ *Out of Network Benefits? Yes____ No____*

*Individual Deduc $*_____ *Amt Met$*_____ *Family Deduc $*_____ *Amt Met $*_____

# of Visits per Calendar Year _____ *Calendar Yr. From* _____*To* _____

Authorization needed? Yes__ No__ *After, Prior/Before*_____*Visit*

Claims Mailing Address _____ *Ph#* _____

_____

Authorization Mailing Address _____*Ph#* _____

_____

*Can Patient be Balanced Billed? YES*_____ *NO*_____

In Network Co-Pay Visit 1- _____ *Out Of Network Co-Pay Visit 1-* _____
Visit _____ *Visit* _____
Visit _____ *Visit* _____