

Last Name: _____ First Name: _____ I MI _____

Mailing Address: _____

_____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Male Female

Social Security Number: _____ Marital Status: S M D W Other

Employer: _____ Position: _____

Work Number: _____

Primary Care Physician: _____ Phone Number: _____

**If this is your first time here,
how did you hear about us?**

Newspaper Radio TV Yellowpages Website Walk-in Flyer/Postcard

Friend/Patient*

*Whom may we thank for referring you to our office? Name: _____

Insurance Information

Policy Holder Name: _____ Date of Birth: _____

Mailing Address: (if same, write same) _____

Relationship to patient: Self Spouse Parent Other _____ -

I authorize the release of any medical information necessary to process this claim. I also request payment of benefits either to myself or to the party that accepts assignment.

Patient's or authorized person's signature

Health Insurance Portability and Accountability Act Notice of Privacy Practices (HIPAA). Our office has a couple of copies of this Act visible by the check in window. Please feel free to read over your rights. We will be more than happy to make a copy for you to take with you.

I acknowledge that I have read, understand, and was offered a copy of the Notice of Privacy Practices.

Patient's or authorized person's signature

Please list current medications on top of back side

