

**PATIENT INFORMATION (Please print)**

Full Name \_\_\_\_\_ Nickname \_\_\_\_\_  
First Middle Last

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Marital Status \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street Apartment # City State Zip

Employment: Company Name \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Individual to contact in an emergency: Full Name \_\_\_\_\_  
 (Please list someone not in your household) First Middle Last

Relationship to patient \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**RESPONSIBLE PARTY/GUARANTOR INFORMATION**

Individual to Receive Bills  Self (Skip this section) or Full Name \_\_\_\_\_  
First Middle Last

Relationship to Patient \_\_\_\_\_ Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street Apartment # City State Zip

Employment: Company Name \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

**MEDICAL INSURANCE INFORMATION (Please submit your card(s) to be copied)**

Insurance Company Name	Card/Policy Holder Name	Policy Number	Card/Policy Holder's Social Security #	Office Visit Copay Amount (\$)
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

**CARD/POLICY HOLDER INFORMATION** Card/Policy Holder is:  Patient  Responsible Party (Skip this section)

Full Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
First Middle Last

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street Apartment # City State Zip

Employment: Company Name \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

**Assignment of Benefit/Consent for Treatment:** I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I hereby voluntarily consent to my treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physicians. I have read this consent, am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to the patient concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

PATIENT SIGNATURE: \_\_\_\_\_  
 GUARDIAN: \_\_\_\_\_

DATE: \_\_\_\_\_  
 DATE: \_\_\_\_\_