Welcome to Our Office

To better serve you, please supply the information indicated as it applies to you.

Last Name _____ First Name _____ M.I. ____ Preferred Name _____

Address

_____

_____

Home Phone _____ Day Phone (Ext.) _____

If the patient is a child :

Parent's Name _____ Parent's Address and Phone Number (If different)

_____

_____

_____

Insurance Information

Insured's Name _____

Address _____

_____

_____

Phone _____

Date of Birth _____

Employer _____

Insurance Company _____

Address _____

_____

_____

Group Name _____

Group # _____

Insured's ID _____

Patient Relationship to Insured :

Self ____ Spouse ____

Child ___

Single ___ Married ___

Other ___

Student FT ___ PT ___

Employed Y ___ N ___

Note : Most insurance policies reimburse only a portion of your total charges. If you have any questions about your coverage, *please contact your representative.* We *do not* guarantee the accuracy of benefit information given to us by insurance companies.

Please understand that financial responsibility for your account is yours, not your insurance company's.

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of benefits either to myself , or to the party who accepts assignment.

Signed _____ **Date** _____