

PATIENT INFORMATION FOR MEDICAL RECORDS (Please Print)										DATE:						
PATIENT		MR. MRS. MISS		LAST NAME				FIRST NAME			MIDDLE					
PATIENT ADDRESS				STREET				CITY			STATE		ZIP			
MAIDEN NAME				HOME PHONE				CELL PHONE			OCCUPATION					
SOCIAL SECURITY NUMBER			AGE	DATE OF BIRTH			PLACE OF BIRTH			SEX M F	DRIVER'S LICENSE NO.					
PATIENT EMPLOYER										BUSINESS PHONE						
EMPLOYER'S ADDRESS				STREET				CITY			STATE		ZIP			
SPOUSE'S NAME				MARITAL STATUS M S D W SEP.				REFERRED BY								
SPOUSE'S EMPLOYER				STREET		CITY		STATE		ZIP		BUSINESS PHONE				
IN CASE OF EMERGENCY, CONTACT: NAME				STREET		CITY		STATE		ZIP		PHONE NUMBER				
MEDICAL INSURANCE INFORMATION																
NAME OF INSURED										SOCIAL SECURITY NUMBER						
COMPANY								GROUP NUMBER/POLICY NUMBER			PHONE NUMBER					
COMPANY								GROUP NUMBER/POLICY NUMBER			PHONE NUMBER					
IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT PLEASE COMPLETE THIS SECTION																
RESPONSIBLE PARTY		MR. MRS. MISS		LAST NAME				FIRST NAME			MIDDLE		RELATION			
ADDRESS				STREET				CITY			STATE		ZIP		PHONE NUMBER	
SOCIAL SECURITY NUMBER			OCCUPATION				EMPLOYED BY									
EMPLOYER'S ADDRESS				STREET				CITY			STATE		ZIP		BUSINESS PHONE	

I hereby authorize \_\_\_\_\_ to furnish to the above insurance company(s) or to a designated attorney, all information which said insurance company(s) or attorney may request. I hereby assign to Dr. \_\_\_\_\_ all money to which I am entitled for medical and/or surgical expense relative to the service rendered by him, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor(s) for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required.

INSURED OR GUARDIAN SIGNATURE

PATIENT'S SIGNATURE