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