

PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____

E-Mail: _____

Marital Status: (circle one) SINGLE MARRIED OTHER

Gender: (circle one) MALE FEMALE

Employer or School (circle one) PART-TIME FULL-TIME

Is patient covered by insurance? NO YES - go to Section B

INSURED INFORMATION:

Patient relationship to Insured: (circle one) SELF SPOUSE CHILD

OTHER

If patient relationship to "insured" is other than "Self" please complete the following.

If the patient is insured, go directly to section C.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security #: - -

Marital Status: (circle one) SINGLE MARRIED OTHER

Employer or School (circle one) PART-TIME FULL-TIME

INSURANCE POLICY INFORMATION

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Plan Name: _____

Policy Number: _____ Group #: _____

Is the patient covered by more than one insurance? (circle one) YES NO

If the patient is not covered by insurance:

I agree to make payment in full: (circle one) YES NO

Method of Payment: (circle one) CHECK CASH CREDIT CARD (if paying by credit - see below)

Credit Card #: _____ Expiration Date: _____

Authorized Signature: _____

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