

**PERSONAL INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ M.I: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIPCODE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

SEX : MALE FEMALE MARITAL STATUS : SINGLE MARRIED

HOME PHONE : \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

SSN: \_\_\_\_\_ OCCUPATION (circle one): EMPLOYED STUDENT OTHER

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY: \_\_\_\_\_ ID# \_\_\_\_\_ GROUP: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ Insured (if not patient) \_\_\_\_\_ DOB: \_\_\_\_\_

PCP: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

SEX M / F

SECONDARY: \_\_\_\_\_ ID# \_\_\_\_\_ GROUP: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ Insured (if not patient) \_\_\_\_\_ DOB: \_\_\_\_\_

SEX: M / F RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER

**AUTHORIZATION OF PAYMENT:** I, the insured and or the patient hereby authorize the provider of services to release medical information concerning my examination and or treatment for purposes of TPO(treatment/payment/operations) and to receive direct payment for medical benefits payable. I hereby certify my eligibility with the above referenced carrier, and guarantee payment in the event that services provided are either not covered or unauthorized by the appropriate entities, and in doing so accept full liability for payment to the provider. In the event my account becomes delinquent, and or is referred to an outside agency for collection, I hereby certify my acceptance to all "realized collection costs" incurred as a result of my indebtedness.

**AUTHORIZATION TO TREAT:** Permission is hereby given to treat minor family member, if any immediate medical attention is needed and I am unavailable to give my consent for treatment. This signed statement shall serve as my authorization for the physician to proceed with whatever medical care deemed necessary until I can be reached.

I, the insured and or patient hereby acknowledge that I have read the HIPAA Notice of Privacy Practices provided to me by this clinic and verify by my signature that I understand fully how information about me may be used and disclosed and how I can gain access to this information.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Print Name for Digital Signature):