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PATIENT LAST NAME: ______________________ FIRST NAME: ________________________ MI: ________

HOME ADDRESS: __________________________________CITY: ____________ STATE: ______ ZIP: ________

SS#: _______________________ SEX: _____ AGE: _______ DOB: _________________

HOME PHONE: ____________________ WORK PHONE: ____________________ CELL PHONE: ____________________

DL#: _______________________ STATE: _________________________

EMERGENCY CONTACT: ____________________________ RELATIONSHIP: _____________ PHONE: ___________________

PATIENT EMPLOYER: ___________________________________ ADDRESS: _______________________________________

CITY: ______________________ STATE: ______ ZIP: ___________ OCCUPATION: ____________________________________

SPOUSE/CUARDIAN LAST NAME: _______________________ FIRST: _________________________ MI:________________

SPOUSE/GUARDIAN ADDRESS: ____

SPOUSE/GUARDIAN SSN#: ____________________ DOB: __________________ WORK#: ______________________________

SPOUSE GUARDIAN EMPLOYER: _________________________ OCCUPATION: _____________________________________

PRIMARY INSURANCE: ____

CLAIMS ADDRESS: ______________________________ CITY: ______________ STATE: __________ ZIP: _________________

ID#: ____________________________ GROUP#: ____

SUSCRIBER'S NAME: __________________________________ RELATIONSHIP TO INSURED: _________________________

SUSCRIBER'S ADDRESS: ____

SUBSCRIBER'S DOB: _________________________________ SUBSCRIBER'S EMPLOYER: ___________________________

SECONDARY INSURANCE: ____

CLAIMS ADDRESS: ______________________________ CITY: ______________ STATE: __________ ZIP: ________________

ID#: ____________________________ GROUP#: ____________________ NAME OF INSURED: __________________________

RELATIONSHIP TO INSURED: ____

SUSCRIBER'S NAME: __________________________________ RELATIONSHIP TO INSURED: _________________________

SUSCRIBER'S ADDRESS: ____

REFERING PHYSICIAN: _________________________________ PRIMARY CARE PHYSICIAN: _________________________

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filling and payment medical Claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST IR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.
I permit a copy of this release to be used in place of the original.

SIGNATURE: ____ DATE: _____________________________________
(SIGNATURE OF INSURED OR AUTHORIZED PERSON, PATIENT OR PARENT IF MINOR)