PATIENT INFORMATION

Name: ____________________________________ Social Security #: ___________________

Date of Birth: ____________________ Sex: ____ Marital Status: _____________________

Address: ____

_______________________________________ Cell Number: ______________________

Home Phone #: __________________________ Work Phone: ______________________

E-mail Address: _________________________ Referring Physician: _______________

Employer: ______________________________ How did you hear of us? _____________

Are you enrolled in Hospice: ______ Name of preferred pharmacy: ______________________

INSURANCE INFORMATION

Insurance Company: _________________________ Phone #: __________________________

Group Number: ___________________ Policy Number: _______________________________

Card Holder's Name: ________________________ Relationship to Patient: ______________

SECONDARY INSURANCE INFORMATION

Insurance Company: ____________________________ Phone #: _______________________

Group Number: ____________________ Policy Number: ______________________________

Card Holder's Name: ___________________________ Relationship to Patient: ____________

EMERGENCY CONTACT

Name: __________________________________ Relationship to patient: _____________

Home Phone #: _____________________ Work Phone #: ______________________________

SPOUSE/ GUARANTOR/ RESPONSIBLE PARTY

Name: ___________________________________ Social Security #: _________________

Date of Birth: _______________ Sex: ____ Marital Status: ___________________

Address: ____

____ Home Phone #: ___________________

Work Phone: _________________ Employer: ____________________________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/ or medical benefits, if any, otherwise payable to me for his/ her services as described, realizing I am responsible to pay non-covered services.

Signature: _______________________________________ Date: ______________________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature: _______________________________________ Date: ______________________