



♡ Patient Information ♡

Name _____ Birth date _____
Address _____ Apt. _____ Social Security _____ - _____ - _____
City _____ State _____ Zip _____ Marital Status M W S D
Phone (____) _____ - _____ Cell (____) _____ - _____ | Male Female (Circle one)
Email Address: _____
Employer Name _____ Empl. Phone (____) _____ - _____
Emergency Contact Name _____ Phone (____) _____ - _____
Referring Physician _____ Phone (____) _____ - _____
Primary Care Physician _____ Phone (____) _____ - _____

♡ Primary Insurance Information ♡

Insurance Name _____ Please provide card
Policy Holder/Subscriber Information | SS# _____ - _____ - _____ Relationship to patient _____
Name _____ Birth Date _____
Employer _____ Empl. Address _____
City _____ State _____ ZIP _____ Phone (____) _____ - _____

♡ Secondary Insurance Information ♡

Insurance Name _____ Please provide card
Policy Holder/Subscriber Information | SS# _____ - _____ - _____ Relationship to patient _____
Name _____ Birth Date _____
Employer _____ Empl. Address _____
City _____ State _____ ZIP _____ Phone (____) _____ - _____

♡Release of information: I authorize the release of information requested by my insurance.

Signature Relationship to Patient Date

♡Financial: I understand that it is my responsibility to provide correct insurance information for claim processing. If information is incomplete or inaccurate I realize I will be responsible to pay for services.

Signature Relationship to Patient Date

♡Treatment: I consent to and authorize medical treatment by the physicians and staff.

Signature Relationship to Patient Date