PATIENT INSURANCE INFORMATION SHEET

PLEASE PRINT CLEARLY AND COMPLETE ALL INFORMATION

PATIENT INFORMATION

Name (Last, First, MI):		
Mailing Address:		
City:	**State:**	**Zip:**
Home Phone:	**Social Security No.**	
Date of Birth:	**Male / Female**	**Marital Status:**
Employer:	**Occupation:**	**Cell/Work No.:**
Employer Address:		
City:	**State:**	**Zip:**
US Citizen: Yes No	**Ethnic Origin: Black White Hispanic Other, spec._____**	

EMERGENCY CONTACT INFORMATION

Name (Last, First, MI):		**Relation to Patient:**
Address:		**Employer:**
City:	**State:**	**Zip Code:**
Home Phone:	**Work Phone:**	**Other Phone:**

PRIMARY INSURANCE INFORMATION

Policy Holder's Name (Insured):	**Copay: $**
Policy ID No.:	**Group No.:**
Policy Holder Social Sec. No.:	**Policy Holder Date of Birth:**
Name of Insurance Co.:	**Phone No.:**
Name of Group or Employer:	**Phone No.:**
Address of Employer:	
City:	**State:**	**Zip:**

SECONDARY INSURANCE INFORMATION

Policy Holder's Name (Insured):	**Copay: $**
Policy ID No.:	**Group No.:**
Policy Holder Social Sec. No.:	**Policy Holder Date of Birth:**
Name of Insurance Co.:	**Phone No.:**
Name of Group or Employer:	**Phone No.:**
Address of Employer:	
City:	**State:**	**Zip:**

I have reviewed this office's Notice of Privacy Practices which is posted in the waiting room. I understand that I am entitled to receive a copy of this document upon request. I authorize payment of medical benefits to this provider for medical services rendered. I authorize the release of medical records or any other information to process claims for medical services. I have reviewed this offices's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Signature of Patient or Personal Representative		**Date**