

CHECK IN TIME _____

CHECK OUT TIME _____

PATIENT: (FIRST AND LAST AS INSURANCE HAS IT LISTED)

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Sex: M F SSN _____ (Circle One) Marital Status: M S W D (Circle One)

Driver's Lic. # _____ Exp: _____ Employer _____

Phone (Home) _____ Work # _____ Cell # _____

Address _____ City _____ State _____ Zip _____

Reason of Visit _____ Referred by _____

IN CASE OF EMERGENCY

EMERGENCY CONTACT (Name) _____

(Phone) _____

(Relationship) _____

PRIMARY INSURANCE POLICY HOLDER

POLICY HOLDER'S NAME _____ SSN _____ DOB _____

INSURANCE NAME _____ INSURANCE I.D. # _____

GROUP# _____ EMPLOYER _____ WORK # _____

(ADDRESS AND PHONE NUMBER IF DIFFERENT FROM PATIENT)

SECONDARY INSURANCE POLICY (if applicable)

POLICY HOLDER'S NAME _____ SSN _____ DOB _____

INSURANCE NAME _____ INSURANCE I.D. # _____

GROUP# _____ EMPLOYER _____ WORK # _____

ADDRESS IF DIFFERENT FROM PATIENT _____

FINANCIALLY RESPONSIBLE PARTY:

PATIENT FATHER OTHER _____
 SPOUSE MOTHER _____

PLEASE READ AND SIGN

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ANY SERVICES RENDERED AT TIME OF VISIT.

- ***Please Note: You may incur separate charges for Laboratory and Orthopedic Services.***
- I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY MY INSURANCE PLAN INCLUDING MEDICARE.
- I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN FOR SERVICES RENDERED.
- I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: A DETAIL OF YOUR RIGHTS AND HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED IS SET FORTH IN THE NOTICE OF PRIVACY PRACTICES. A COPY HAS BEEN FURNISHED TO ME AND IS POSTED IN THE CLINIC.

PATIENT SIGNATURE _____ **Date** _____