Welcome to Our Office!

Patient Information	
Name	Patient Birth Date (mm/dd/yyyy)
Address	
City	Zip
Occupation	Employer
Home Phone	Work Phone

Insurance Information	
Primary Insurance Company	
Insurance ID Number	
Subscriber Name	Birth Date
Relationship to Subscriber (Please circle one): Self Spouse Dependent Child	
Secondary Insurance Company	
Insurance ID Number	

****Please present any insurance cards and forms to the receptionist.**

I authorize the release of any medical or other information to process my insurance claims. I also authorize payment of medical benefits to my doctor. It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for service performed by that doctor. I also understand that I am responsible for any charges not covered by my insurance.

Patient Name (Please Print)	Date
Patient Signature	