Email (PLEASE PRINT) Home Phone (_ Patient Information – Name First Name Address _ Cell Phone (State ____ Sex M F Age Birthdate ☐ Married Widowed Single Minor ☐ Separated Divorced Partnered for _____ years Preferred Pharmocy: Occupation_ Employer/School Address. Employer/School Phone (____)___ Whom may we thank for referring you? ___ In case of emergency who should be notified? _ Phone (- Primary Insurance -Person Responsible for Account Last Name First Name Middle Initial Relation to Patient_ Birthdate _____ Soc. Sec. # ____ _____ Phone (____ Address (If different from patient's)_____ _____ State ____ Occupation ___ Person Responsible Employed by_____ Business Address _ Business Phone (____) Insurance Company_ Group #_____ Subscriber # ____ Names of other dependents covered under this plan __ - Additional Insurance -Is patient covered by additional insurance? Yes No. Relation to Patient Subscriber Name Address (If different from patient's)_____ _____ Phone (____) ___ ____ Zip ____ _____State Subscriber Employed by __ Business Phone () Soc. Sec. # Insurance Company ___ Group # _____ Subscriber # ___ Names of other dependents covered under this plan_ - Assignment and Release -I certify that I, and/or my dependent(s), have insurance coverage with Name of Insurance Company(ies) all insurance benefits, if any, otherwise payable to me for services rendered. I understand assign directly to Dr. that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

> See Other Side

Date

Relationship to Patient

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Please complete the following so that we may con	atact you properly and securely.	
Please list the family members or other persons, if any,	News	
whom we may inform about your general medical	Name	
condition and diagnoses (including treatment, payment and health care operations).	LIMIRE	
	ranc	
	Phone	
 Please list the family members or significant others, 	Nama	
if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.	Phone	
	Name	and the second s
Place wint the address ()		
Please print the address of where you would like your billing statements and /		
billing statements and / or correspondence from our office to be sent if other than your home.	Annual State Annual State Stat	
to be sent if other than your nome.	The state of the s	
Please print the telephone number where you want		
to receive calls about your appointments, lab and		
X-ray results, or other health care information if other	10000	
than your home telephone number.		
Please be aware that a cell phone is not a secure and private		
that a cert phone is not a secure and private	line,	
Please indicate if you want all correspondence from our office	e sent in a scaled envolue and a work with the	
		☐ Yes ☐ No
Can confidential messages (i.e., appointment reminders) be left	on your telephone answering machine or voicemail?	☐ Yes ☐ No
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PATIENT NAME print	Comment of the Commen	
PATIENT SIGNATURE	Date	
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