Physician ______________________ **Chart Number** ______________

Patient Information

Patient Name (first, middle, last) ______________________

Social Security Number ______________________

Birth Date ______________________ Sex ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner

Address ______________________

City/State/Zip ______________________

Phone: Home __________ Cell __________ Work __________

Email ______________________

Ethnic Origin: ☐ Native American ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other __________

Primary Language ______________________

Emergency Contact Information

Name ______________________

Relationship to Patient __________ Phone Number __________

Guarantor Information (Financially Responsible Party)

☐ Check if information is same as above

Name (first, middle, last) ______________________

Social Security Number ______________________

Birth Date ______________________ Sex ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner

Address ______________________

City/State/Zip ______________________

Phone: Home __________ Cell __________ Work __________

Guarantor's Relationship to Patient ______________________

Employer Name __________ Occupation __________

Address ______________________

City/State/Zip ______________________

Release of Information

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for any amount not covered by my insurance. I request that payment of authorized Medicare benefits be made to my physician.

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Signature of Patient (Parental Signature if Minor) Date