Patient Information Date:

Mr. Mrs. Ms. Miss. Dr. _____ Marital Status: *Married Single Divorced*

Name Last Name: First MI Nickname

Address City State Zip

Phone
home cell work

Date of birth: SS#

Employment

Student: full/ part School: Can we e-mail and or text to contact you? Yes No

Guarantor, Relationship [If you are filling form out for a child, please list YOUR information here]

Name: Last Name: First MI Nickname

Address:

Phone: Home Work Cell

e-mail: SS # Date of birth:

Insurance Information

Employment

Health / Major Medical Care Insurance [separate from Vision Coverage]

Primary:
Insurance Company ID#

Name of Insured

Secondary
Insurance Company ID #

Vision Plan/Coverage

Primary Plan: ID#

Secondary Plan: ID#

REFERRALS NEED TO BE PRESENTED AT THE DAY Of THE EXAM

Appointment cancellation or no show without 24 hours notice incurs a charge of $50.00. All Co-Pays due at visit.
Payments accepted: Cash--Debit Card (MasterCard/Visa)
and Credit Card (MasterCard / Visa/ Discover)

1. I authorize release of information to all my insurance companies
2. I authorize my insurance company to send payment directly to my doctor.
3. I understand that I am responsible for my bill, and there may be charges that my insurance does not cover, and I will pay for those non-covered services.
4. I give my consent to electronic filing of my insurance claims and prescriptions.
5. I understand that it is my responsibility to obtain a referral for service if it is required by my insurance company.

If I do NOT have the necessary referrals required by my Insurance company, I will be responsible for payment of services rendered.

Signature on File

Print Patient's Name Patient Signature (or Parent/Guardian/Guarantor)

Today's Date Printed Name of Parent/Guardian/Guarantor

Rev. emg 01/14