PATIENT INFORMATION

First Name __________________________ Mid Init ______ Last Name ________________________________

Address ________________________________City_________________State ________________Zip________

Home Phone ____________________ Cell Phone ____________________ Work Phone ___________________

SS# __________________ DOB: _________ Age: ______ Email Address _______________________________

Employers Name ___________________________ Address ____

Occupation _____________________________ **REFERRING PHYSICIAN**___________________________

Address ____ **Phone** _________________________________

INFORMATION OF PERSON RESPONSIBLE FOR BILLING

First Name __________________________ Mid Init _____ Last Name _________________________________

Address ____

Home Phone ______________________ Cell Phone ____________________ Work Phone _________________

Employers Name ___________________________ Address ____

Email Address ___________________________________ **To be used only if phone contact not available.**

Name and phone of nearest friend or relative not living with you _______________________________________

INSURANCE INFORMATION

Medicaid # ______________________________ Medicare # _____________________

BCBS # ________________________ Grp # _______________ DOB of policy holder __________________

Other ____

Preferred Pharmacy Name _____________________ Phone _______________ Fax _____________________

** Note – All prescriptions will be sent to this pharmacy until patient notifies of a change.

Please circle each one that applies:
Patient is: Male or Female Employed, Unemployed, Retired, Student Married, Single, Divorced, Widowed
Caucasian, African American, Hispanic, Middle Eastern, Near Eastern, Other ___________________

I authorize the release of any medical information necessary to process insurance claims and request payment of benefits either to myself or to the party who accepts assignment.

____ Date ____________________

I understand the providers charge may exceed the insurance payments, and if greater than such payment, I will be responsible for that amount **only on non-par insurances.**

____ Date _______________________