

# ADULT

Over 18 not a full-time student

PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED.  
(PRINT AND PRESS HARD.)

## INSURANCE AUTHORIZATION AND ASSIGNMENT

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE SIGN  
BY BOTH X'S

I authorize payment of medical benefits to undersigned physician or supplier for these services and all future claims.

X \_\_\_\_\_  
Signed (Insured or Authorized Person)

I authorize the release of any medical information necessary to process this claim and all future claims

X \_\_\_\_\_  
Signed (Insured or Authorized Person)

### PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Nickname \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: (circle one) Male Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Home Phone: ( ) \_\_\_\_ - \_\_\_\_

Soc. Sec. No.: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Is the Patient currently employed? (circle one) Yes No

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_ - \_\_\_\_ Extension: \_\_\_\_ Cell Phone: ( ) \_\_\_\_ - \_\_\_\_

Is the Patient a Student? (circle one) Yes No If YES, name of School: \_\_\_\_\_

Is the Patient? (circle one) Single Married Partner Separated Divorced Widowed

If you circled Married, please complete Spouse information below.

Spouse's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Nickname \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Is Spouse currently employed? (circle one) Yes No

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_ - \_\_\_\_ Extension: \_\_\_\_ Soc. Sec. No.: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

### REFERRING PHYSICIAN

Who is the Patient's Referring Physician? \_\_\_\_\_  
Name Address Phone

Is the Patient's Primary Care Physician the Same? (circle one) Yes No

If no, \_\_\_\_\_  
Name Address Phone

### NEXT OF KIN INFORMATION

Give the name of nearest relative or of a close friend not living with you, to contact in case of an emergency.

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

### INSURANCE INFORMATION

In order to avoid error or delay in the processing of your insurance claim, if is essential that the following section be completely filled out

Does the Patient have health insurance? (circle one) Yes No Please circle if you are a member of a: HMO PPO

Medicare Number: \_\_\_\_\_ Medicaid State ID Number: \_\_\_\_\_

If the Patient's services are covered by Medicare or Medicaid, please show your ID card to the receptionist.

Is this visit related to a work injury? (circle one) Yes No If Yes, Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this visit related to an auto accident? (circle one) Yes No If Yes, Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### PATIENT'S HEALTH INSURANCE

Insurance Company: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Area Code: ( ) Phone: \_\_\_\_\_

Policy Holder \_\_\_\_\_  
First Name Middle Initial Last Name

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Employer: \_\_\_\_\_

Group No.: \_\_\_\_\_ ID No.: \_\_\_\_\_

#### PATIENT'S OTHER INSURANCE (Secondary Health, Worker's Comp. or Auto Ins.)

Insurance Company: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Area Code: ( ) Phone: \_\_\_\_\_

Policy Holder \_\_\_\_\_  
First Name Middle Initial Last Name

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Employer: \_\_\_\_\_

Group No.: \_\_\_\_\_ ID No.: \_\_\_\_\_

### OFFICE POLICY

It is customary to pay for services when rendered unless other arrangements have been made in advance.