



Whom may we thank for referring you? _____

Patient Name: _____ Birth date: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

SSN: _____ Male Female

Home phone: _____ Minor Single Married Widowed

Patient's employer: _____ Work phone: _____

Occupation: _____ Cell phone: _____

Employer's address: _____

E-mail: _____

Chief complaint / reason for visit: _____

Please indicate any allergies you have to medications: _____

Describe any condition we should know about (i.e.: hypertension, diabetes, etc.): _____

Current medications (including non-prescription): _____

Family physician: _____ Phone: _____

Address: _____

Insurance Information:

Name of primary insurance: _____

Name of insured: _____ Relationship: _____

Birth date: _____ SSN#: _____

Do you have a secondary insurance? YES NO

Name of secondary insurance: _____

Name of insured: _____ Relationship: _____

Birth Date: _____ SSN#: _____

Disclosure of Benefits

I have received a copy of the HIPPA Privacy Notice and authorize release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and/or administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature of patient or patient representative _____ Date _____