PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____

Sex:___ Marital Status:_____ Social Security:_____

Mailing Address:_____

City, State, Zip:_____

Home Phone:_____ Cell Phone:_____

Employer:_____

Primary Insurance:_____Secondary Insurance:_____

Primary Care Physician (PCP):_____

Preferred Pharmacy:_____ Town:_____

Emergency Contact:

Name:_____ Phone:_____

Relationship:_____

Address:_____

May we contact you by: (yes or no)
1.**Phone**_____
2.May we leave a message on your **answering machine**? _____
3.May we leave a message with a **family member**? _____
4. May we leave a mesaage with your **spouse/significant other**?____

Please list who may receive your personal health information:
Name:_____ Relationship:_____
Name:_____ Relationship:_____

We occasionally send information regarding your care to your primary care physician and or referring doctor. We are required to release information to your insurance company.

I hereby authorize and assign my insurance benefits (VA patient exempt) to be paid directly to the physician and or facility. I understand that I am financially responsible (VA patient exempt) for all non-covered services. I also authorize the release any information required in processing this claim.

Signed:_____ Date:_____