

PATIENT INFORMATION

MR #: _____

Name: _____ Date: _____

LAST FIRST MIDDLE

Address: _____

STREET APARTMENT # CITY STATE ZIP

Home Ph. () _____ Cell Ph. () _____ Patient Soc. Sec. # _____

Date of Birth: _____ Age: _____ Sex: Male Female Marital Status: S M W D

Patient's Employer: _____ Occupation: _____

Work Ph. () _____ Email: _____

Spouse's Name: _____ Occupation: _____

Spouse's Employer: _____ Business Phone: () _____

IF PATIENT IS A MINOR, COMPLETE MOTHER & FATHER INFORMATION:

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Employer: _____ Employer: _____

Home #: () _____ Work #: () _____ Home #: () _____ Work #: () _____

PHARMACY: Name, address, city, phone and fax numbers of your preferred pharmacy:

NAME	ADDRESS	CITY & STATE	PHONE #	FAX #

IN CASE OF EMERGENCY: Name and address of relative/friend not living at same address:

Name: _____ Relationship: _____

Address: _____ Phone: () _____

Did a doctor send you to our clinic? Yes* No

* If YES, please list the doctor's name: _____

Who is your Primary Care Doctor? Same as above or List name _____

INSURANCE INFORMATION

PRIMARY COMPANY: _____ () PPO Plan () HMO Effective Date: _____

Insurance Company Address: _____

STREET SUITE # CITY STATE ZIP

Policyholder's Soc. Sec. No.: _____ Insurance Phone #: () _____

Policy #: _____ Group #: _____

Policyholder's Name: _____ Birthday: _____ Sex: Male Female

SECONDARY COMPANY: _____ () PPO Plan () HMO Effective Date: _____

Insurance Company Address: _____

STREET SUITE # CITY STATE ZIP

Policyholder's Soc. Sec. No.: _____ Insurance Phone #: () _____

Policy #: _____ Group #: _____

Policyholder's Name: _____ Birthday: _____ Sex: Male Female

IF TRICARE insured: Prime (*need referral) Standard Branch of Service: _____ Active Retired

ACCIDENT INFORMATION

Accident Related To: Work Auto Other Date of Accident: _____ Time of Day: _____

INSURANCE AUTHORIZATION

I request that payment of authorized Medicare (or other insurance or third party) benefits be made either to me or on my behalf to Drs. Barber, Cash, Colclasure, Dickins, Gardner, Hearnberger, Langston, McGhee, Miller, Morris, Smith, Stern, Williamson, Wilson, et al for any services furnished me by these physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration/CMS and its agents (or other insurance co. or third party payer) any information needed to determine these benefits or the benefits payable for related services. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

SIGNATURE X _____

DATE _____