PATIENT INFORMATION

LAST NAME _____MIDDLE INITIAL_____FIRST NAME_____
MISS_____MR_____MRS_____DR_____OTHER_____
SINGLE_____MARRIED_____OTHER_____

STREET ADDRESS_____
CITY_____STATE_____ZIPCODE_____
HOME PHONE_____CELLPHONE_____
EMPLOYER_____WORK PHONE_____
EMAIL ADDRESS_____
BIRTHDATE_____SSN_____

PERSON RESPONSIBLE FOR BILLING

(if same as patient, write "same as above")

LAST NAME _____MIDDLE INITIAL_____FIRST NAME_____
MISS_____MR_____MRS_____DR_____OTHER_____
SINGLE_____MARRIED_____OTHER_____

STREET ADDRESS_____
CITY_____STATE_____ZIPCODE_____
HOME PHONE_____CELLPHONE_____
EMPLOYER_____WORK PHONE_____
EMAIL ADDRESS_____
BIRTHDATE_____SSN_____

INSURANCE INFORMATION

(if insured is other than self)

INSURANCE CARRIER_____
LAST NAME _____MIDDLE INITIAL_____FIRST NAME_____
STREET ADDRESS_____
CITY_____STATE_____ZIPCODE_____
HOME PHONE_____CELLPHONE_____
EMPLOYER_____WORK PHONE_____
BIRTHDATE_____SSN_____
RELATIONSHIP TO INSURED: SPOUSE_____CHILD_____OTHER_____
IF OTHER, PLEASE EXPLAIN:_____

SIGNATURE ON FILE AUTHORIZATION:

( ) I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS
( ) I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES
( ) I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES
( ) I AUTHORIZE PAYMENT DIRECT TO MY DOCTOR
( ) I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL

SIGNATURE_____DATE_____