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.	I authorize the release of any medical information necessary to process this claim and all future claims.
X ______________________ Signed (Insured or Authorized Person)	**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: ______________ Employer Address: ______________ Occupation: ______________

Work Phone: ( ) _______ - _______ Extension: _______

Is the Patient a student? (Circle one) Yes No If YES, name of school: ______________

Is the Patient? (Circle one) Single Married 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 the Spouse currently employed? (Circle one) Yes No

Employer: ______________ Employer Address: ______________

Work Phone: ( ) _______ - _______ Extension: _______ Soc. Sec. No.: _______ - _______ - _______

Who is the Patient's Referring Physician? ______________

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, **it 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: _______ - _______ - _______

Claim #: ______________

Group No.: ______________ ID No.: ______________

Adjuster Name: ______________

PLEASE CHECK THE APPROPRIATE BOX BELOW TO HELP US DETERMINE HOW YOU WERE REFERRED TO OUR OFFICE.

☐ PHYSICIAN First Name ______________ Last Name ______________ [SP] [PHY]

☐ ONE OF OUR PATIENTS [PAT] ☐ FRIEND [FR] ☐ RELATIVE [RL]

First Name ______________ Last Name ______________

MAY WE PERSONALLY THANK THEM? ☐ YES ☐ NO

PLEASE GIVE US THEIR ADDRESS ______________ [LET]

OTHER: (*PLEASE SPECIFY*)

☐ YELLOW PAGES WHICH? ______________ [YP]

☐ HEALTH MAINTENANCE ORGANIZATION (HMO) WHICH? ______________ [HMO]

☐ EMERGENCY ROOM WHICH? ______________ [ER]

☐ REFERRAL SERVICE WHICH? ______________ [RS]

☐ PREFERRED PROVIDER ORGANIZATION (PPO) WHICH? ______________ [PPO]

☐ OTHER PLEASE EXPLAIN ______________ [OTH]