

<b>PATIENT INFORMATION FOR MEDICAL RECORDS (Please Print)</b>						DATE:		
<b>PATIENT</b>	MR. MRS. MISS	LAST NAME		FIRST NAME		MIDDLE		
	PATIENT ADDRESS		STREET		CITY		STATE ZIP	
MAIDEN NAME		HOME PHONE		CELL PHONE		OCCUPATION		
SOCIAL SECURITY NUMBER		AGE	DATE OF BIRTH	PLACE OF BIRTH		SEX M F	DRIVER'S LICENSE NO.	
PATIENT EMPLOYER						BUSINESS PHONE		
EMPLOYER'S ADDRESS		STREET		CITY		STATE ZIP		
SPOUSE'S NAME		MARITAL STATUS M S D W SEP.		REFERRED BY				
SPOUSE'S EMPLOYER		STREET		CITY		STATE ZIP BUSINESS PHONE		
IN CASE OF EMERGENCY, CONTACT: NAME		STREET		CITY		STATE ZIP PHONE NUMBER		
<b>▼ MEDICAL INSURANCE INFORMATION</b>								
NAME OF INSURED						SOCIAL SECURITY NUMBER		
COMPANY				GROUP NUMBER/POLICY NUMBER		PHONE NUMBER		
COMPANY				GROUP NUMBER/POLICY NUMBER		PHONE NUMBER		
<b>▼ IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT PLEASE COMPLETE THIS SECTION</b>								
<b>RESPONSIBLE PARTY</b>	MR. MRS. MISS	LAST NAME		FIRST NAME		MIDDLE		RELATION
	ADDRESS		STREET		CITY		STATE ZIP PHONE NUMBER	
SOCIAL SECURITY NUMBER		OCCUPATION		EMPLOYED BY				
EMPLOYER'S ADDRESS		STREET		CITY		STATE ZIP BUSINESS PHONE		

I hereby authorize \_\_\_\_\_ to furnish to the above insurance company(s) or to a designated attorney, all information which said insurance company(s) or attorney may request. I hereby assign to Dr. \_\_\_\_\_ all money to which I am entitled for medical and/or surgical expense relative to the service rendered by him, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor(s) for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required.

\_\_\_\_\_  
INSURED OR GUARDIAN SIGNATURE

\_\_\_\_\_  
PATIENT'S SIGNATURE