PATIENT INFORMATION: **DATE:** _____

Name (Last, First, M.I.) _____

Address _____

City, State & Zip _____

Telephone Number (home) _____ (work) _____

Birthdate ____/____/____ Age _____ Social Security # _____

Person to contact in case of emergency, Name _____ Phone # _____

Patient Status: Married _____ Single _____ Widowed _____ Other _____
Legally Separated _____ Divorced _____

Employment Status: Employed, Full-time _____ Employed, Part-time _____ Retired _____
Not Employed _____ Student, Full-time _____ Student Part-time _____

Employers Name _____

Address & Telephone Number _____

Primary Care Physician: _____ Referred by: _____

Relationship to Guarantor: Self _____ Spouse _____ Child _____ Other _____

RESPONSIBLE PARTY FOR INSURANCE:

Name (Last, First, M.I.) _____

Address _____

City, State & Zip _____

Telephone Number _____ Social Security # _____

Insured Employer's Name _____

Address & Telephone Number _____

INSURANCE INFORMATION:

Primary Insurance Company _____

Insurance Address _____

Policyholder's Name _____

Policyholder's Birthdate ____/____/____ Policyholder's Sex _____

Group # _____ Policy # _____ Effective Date _____

Secondary Insurance Company _____

Insurance Address _____

Policyholder's Name _____

Policyholder's Birthdate ____/____/____ Policyholder's Sex _____

Group # _____ Policy # _____ Effective Date _____

Other family members seen in this office: _____

ASSIGNMENT AND RELEASE:

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any noncovered services. I also authorize the physician to release any information required to process this claim. I agree that this office may release records pertaining to my treatment including HIV and communicable diseases to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I understand the physicians in this office are independent corporations, not in association with one another.

SIGNED _____ DATE ____/____/____

Which doctor do you see? ☐ **McKernan** ☐ **Folkestad** ☐ **Luley**