

Today's Date _____

Your Name _____ **Date of Birth** _____

Social Security # _____ **Employer** _____
required only if insurance claims filed by our office

Home Address _____ **E-mail** _____
Street City Zip

Home Phone _____ **Work** _____ **Mobile** _____

Name of Spouse / Partner _____ **Date of Birth** _____

Social Security # _____ **Employer** _____
required only if insurance claims filed by our office

Home Address _____ **E-mail** _____
Street City Zip

Home Phone _____ **Work** _____ **Mobile** _____

Names of Children	Date of Birth	Age	Sex	Living Where?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

In case of emergency, please notify:

Name _____ **Relationship** _____

Address _____ **City/State** _____ **Zip** _____
Street

Home Telephone _____ **Work Telephone** _____

Name of person (s) responsible for the bill: _____

Method of payment: Cash Check Other _____

Will you be submitting health insurance claims? Yes No

Name of Insurance Company _____

Telephone Number _____ **Group Name or #** _____

Subscriber Name _____ **Plan# or Type** _____

How were you referred to this office? _____

Family Physician: _____

Medications taken / by whom? _____

I understand that I am financially responsible for the payment of all charges rendered to me or to any members of my family and that payment is expected at the time service is rendered, regardless of any insurance coverage I may anticipate. I further understand that there will be a charge for appointments not cancelled 24 hours in advance, unless the appointed time can be filled. I understand that, should any legal action be necessary to collect any amounts owed by me, I will be responsible for any and all costs and attorney fees. I have read and understand the above statements, and I have received a copy of this agreement.

Signature Date Signature Date