Patient Information

Name:_____D.O.B.:_____

SSN:_____-____-_____ Sex: M F Marital Status:_____

Phone:_____ Work:_____ Cell:_____

E-Mail:_____

Address:_____City:_____State_____Zip:_____

Race:_____ Ethnicity:_____ Preferred Language:_____

Height:_____ Weight:_____ Shoe Size:_____

Primary Care Physician:_____

Pharmacy:_____ Phone Number:_____

Pharmacy Address:_____

Emergency Contact

Name:_____ Relationship:_____Phone Number:_____

Insurance Information

Primary Insurance:_____ **Policy #**_____

Policy Holder:_____ D.O.B._____

Secondary Insurance:_____ Policy #_____

Policy Holder:_____ D.O.B.-_____

INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made to the above facility on my behalf, for any services provided to me. I authorize any holder of medical and other information about me can be released to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, or any other information needed to determine benefits for related services. I agree to pay for all charges not covered by my insurance. I authorize a copy of this authorization to be used in place of the original document.

Signed:_____**Date:**_____