PATIENT INFORMATION: DATE: _____

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

Address _____ Apt._____

City, State & Zip _____

Telephone Number (home) _____ (work) _____ (cell) _____

Email Address _____

Birth date _____/_____/_____ Age _____ Social Security # _____

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

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

Race: White _____ Asian _____ African-American _____ American Indian _____

Other _____ Refused _____

Employment Status: Employed, Full-time _____ Employed, Part-time _____ Retired _____

Not Employed _____ Student, Full-time _____ Student Part-time _____

Employers Name _____

Primary Care Physician: _____ Referred by: _____

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

RESPONSIBLE PARTY FOR INSURANCE:

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

Address _____ Apt._____

City, State & Zip _____

Telephone Number _____ Social Security # _____

Insured Employer's Name _____

INSURANCE INFORMATION:

Primary Insurance Company _____

Insurance Address _____

Policyholder's Name _____

Policyholder's Birth Date _____/_____/_____ Policyholder's Sex _____

Group # _____ Policy # _____ Effective Date _____

Secondary Insurance Company _____

Insurance Address _____

Policyholder's Name _____

Policyholder's Birth Date _____/_____/_____ Policyholder's Sex _____

Group # _____ Policy # _____ Effective Date _____

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 non covered services. I also authorize the physician to release any information required to process the 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? ❒ **Bass** ❒ **Hu** ❒ **Erickson** ❒ **Brotsky**