RESPONSIBLE PARTY FOR PAYMENT

Patient is primary insured (If you are primary insured, continue to "Insurance Information" section below).

Other Responsible Party: Parent Sponse Other ______________________________

NAME ______________________________ DATE OF BIRTH: _______/_____/________________
(Last) (First) (MI)

SOCIAL SECURITY NUMBER ___________-_____-_________
(SSN required for identification and insurance billing)

ADDRESS: ____
(Street, City, State, Zip Code)

HOME PHONE: __(___)_________________ ALTERNATE PHONE: _(____)______________________

CELL WORK OTHER ______________

EMPLOYER: ______________________________ ______________________________
(Employer Name) (Occupation)

____
(Street) (City, State, Zip Code) (Phone #)

INSURANCE INFORMATION

DO NOT COMPLETE IF Insurance Card Provided Self Pay

If Motor Vehicle accident – agents name,
Address, phone #: ______________________________

____

If Medicare: Date of retirement _____/____/________ or Disability

REASON FOR VISIT

ILLNESS **INJURY** ______________________________
(If injury, please indicate HOW, WHEN, and WHERE)

WHAT ARE YOUR SYMPTOMS TODAY? ______________________________

Have you been treated for this illness/injury before? ______________________________
(where and when)

NAME OF DOCTOR/PCP: ______________________________