# GENERAL PATIENT INFORMATION

*(This information is necessary for our files and will be considered confidential)*

DATE _____

PATIENT'S LAST NAME _____ FIRST NAME _____ MIDDLE _____ (___) HOME PHONE _____

CURRENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ HOW LONG? _____

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS AT CURRENT ADDRESS) _____

SOCIAL SECURITY NUMBER _____ DRIVER'S LICENSE NUMBER _____ (___) WORK PHONE _____

EMPLOYED BY _____ EMAIL ADDRESS _____

OCCUPATION _____ DATE OF BIRTH _____ AGE _____ SEX ❑ MALE ❑ FEMALE

LANGUAGE PREFERENCE: ❑ ENGLISH ❑ OTHER _____ SPECIFY

RACE/ ETHNIC ORIGEN: ❑ AMERICAN ❑ ASIAN ❑ AFRICAN AMERICAN ❑ HISPANIC ❑ EUROPEAN ❑ OTHER

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ SEPARATED ❑ DIVORCED

NAME OF PERSON TO IDENTIFY IN CASE OF EMERGENCY _____ RELATIONSHIP _____ (___) EMERGENCY PHONE _____

CURRENT STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

# INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

ADDRESS _____ GROUP OR LOCAL NUMBER _____

SUBSCRIBER'S NAME/DATE OF BIRTH _____ SUBSCRIBER'S SOCIAL SECURITY NUMBER _____ SUBSCRIBER'S I.D. NUMBER _____

SUBSCRIBER'S RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ OTHER _____

SECONDARY INSURANCE COMPANY _____

ADDRESS _____ GROUP OR LOCAL NUMBER _____

SUBSCRIBER'S NAME/DATE OF BIRTH _____ SUBSCRIBER'S SOCIAL SECURITY NUMBER _____ SUBSCRIBER'S I.D. NUMBER _____

SUBSCRIBER'S RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ OTHER _____

# INSURANCE ASSIGNMENT

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to the Doctor the amount(s) due on my claim for services rendered to me or my dependant. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Doctor for the payment of the entire bill.

PATIENT'S SIGNATURE _____ DATE _____

INSURED'S SIGNATURE _____ DATE _____

DATE _____

DOCTOR'S SIGNATURE _____