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RESPONSIBLE PARTY FOR BILLING

RESPONSIBLE PARTY NAME	SEX MALE ☐ FEMALE ☐	BIRTHDATE	TELEPHONE (HOME)	TELEPHONE (CELL)	REFERRING DOCTOR SOURCE	Legal Representative? YES ☐ NO ☐
STREET ADDRESS	CITY	STATE	ZIP	SOC SEC NUMBER		
EMPLOYER NAME	EMPLOYER STREET ADDRESS	DRIVER'S LICENSE NUMBER				
CITY	STATE	ZIP	TELEPHONE	How did you hear about us?		

PATIENT INFORMATION

PATIENT NAME	BIRTHDATE	SEX MALE ☐ FEMALE ☐	PATIENT RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐	MARITAL STATUS MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED ☐	AGE
PATIENT STREET ADDRESS	CITY	STATE	ZIP	SOC SEC NUMBER	
TELEPHONE (HOME)	TELEPHONE (CELL)	STUDENT STATUS FULL TIME ☐ PART TIME ☐	PERSON TO CONTACT IN CASE OF EMERGENCY NAME: PHONE:	DRIVER'S LICENSE NUMBER	
PATIENT EMPLOYER NAME	TELEPHONE	EMPLOYER STREET ADDRESS	CITY	STATE	ZIP

INSURANCE INFORMATION

INSURANCE POLICYHOLDER'S NAME (If different from Patient Name)	INSURANCE CARRIER NAME	GROUP NAME	GROUP NUMBER	POLICY I.D. NUMBER	PATIENT RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐
INSURANCE CLAIM CENTER ADDRESS	CITY	STATE	ZIP	TELEPHONE	EMPLOYER PLAN COVERAGE?
INSURANCE POLICYHOLDER'S ADDRESS	CITY	STATE	ZIP	TELEPHONE	INSURED SOC. SEC. NUMBER / BIRTHDATE
EMPLOYER NAME OF INSURED	EMPLOYER ADDRESS OF INSURED	CITY	STATE	ZIP	TELEPHONE EXT.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I authorize the release of information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health care to:

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This assignment will remain in effect until revoked by me in writing. A Photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responssible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

signed: _____ date: _____