

( ) Strawser  
( ) Goode

( ) Turner  
( ) Dluzniewski

( ) Spellings  
( ) Lewis

PATIENT NAME:

LAST: FIRST: MIDDLE:

ADDRESS GENDER: DATE OF BIRTH  
M / F

CITY STATE ZIP MARTIAL STATUS: S/M/D/W

SOCIAL SECURITY # DRIVERS LICENSE #  
( ) HOME PHONE ( ) WORK PHONE ( ) CELL PHONE

EMPLOYER

PLEASE PRESENT YOUR INSURANCE CARD & DRIVERS LICENSE TO FRONT DESK

<b>PRIMARY INSURANCE:</b> _____	<b>SECONDARY INSURANCE:</b> _____
<b>POLICY HOLDER ID #</b> _____	<b>POLICY HOLDER ID #</b> _____
<b>GROUP #</b> _____	<b>GROUP #</b> _____
<b>POLICY HOLDER NAME:</b> _____	<b>POLICY HOLDER NAME:</b> _____
<b>POLICY HOLDER DATE OF BIRTH:</b> _____	<b>POLICY HOLDER DATE OF BIRTH:</b> _____
<b>EMPLOYER:</b> _____	<b>EMPLOYER:</b> _____
<b>PATIENTS RELATIONSHIP TO POLICY HOLDER:</b> _____ <b>SELF</b> _____ <b>SPOUSE</b> _____ <b>CHILD</b>	<b>PATIENTS RELATIONSHIP TO POLICY HOLDER:</b> _____ <b>SELF</b> _____ <b>SPOUSE</b> _____ <b>CHILD</b>

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for any services furnished. I authorize any holder of medical information about me or my dependents to release to the insurance company for information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original until revoked. I understand that I am financially responsible for all charges whether or not covered by insurance.

PATIENT /GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Patients information updated : \_\_\_\_\_

### Patient Information

