Today's Date: _____

Patient Information

Name _____ Gender Select... Birth date: _____

Mailing Address _____ SS# _____ Marital Status: _____

_____ Occupation _____

_____ Employer _____

Home phone _____ Cell phone _____ Msg OK? ☐

- Please send me appointment reminders via text message.
- I don't have text message service. Please send appointment reminder via ☐ cell ☐ home VM mail

Email:_____

Please note: Email correspondence and text messaging is not considered to be a confidential mode of communication.

Emergency Contact: _____

Relationship:_____ Phone number: _____

Insurance Information

Insured Party (IP) if other than Patient:_____ IP DOB: _____

Relationship to Patient: _____ IP Phone #: _____

Health Plan or Patient ID #: _____ Group ID #: _____

Plan Name: _____ Issue Date: _____

Authorization #: _____ Deductible: $_____

Co-insurance/Co-pay? ☐ No Yes:

SuperBill? ☐ yes ☐ no

Primary Care Coordination

Primary Care MD: _____ Phone: _____

Treatment Coordination Requested? ☐ yes ☐ no Authorization Signed? ☐ yes ☐ no

Referred by _____

Complete If Person Responsible For Payment Is Other Than Patient

Name:_____ Relationship to patient: _____

☐ Please bill to mailing address: _____

☐ Please bill via electronic invoice: (Email Address) _____

Contact Phone: _____

I hear-by certify that the information furnished by me in support of this document is true and correct to the best of my knowledge.

_____ _____ _____ _____

Patient Date Responsible Party Date