



Patient Information

Patient's Name Last Name First Name MI Sex: Male or Female

Birthdate Place of Birth Age Marital Status

Street Address Street City State ZIP Code

Home Phone ( ) Work Phone ( ) Cell Phone ( )

Employer Occupation Preferred Contact Cell Home Work

Work Address Street City State ZIP Code

Preferred Language

- English Spanish Other I'd rather not report

Ethnic Origin

- Hispanic / Latino Not Hispanic / Latino I'd rather not report

Race

- American Indian or Alaska Native Asian Black or African American Hispanic Origin Native Hawaiian or Pacific Islander White Other I'd rather not report

Social Security Number

Email Address

Guarantor Information (For Patients Under Age 18) and Billing Information

Guarantor's Name Last Name First Name MI Relationship

Birthdate Age Sex Marital Status

Billing Address Street City State ZIP Code

Insurance Information

Subscriber's Name Last Name First Name MI Relationship

Birthdate Sex Social Security Number

Street Address Street City State ZIP Code

Employer Work Phone ( )

Work Address Street City State ZIP Code

Emergency Contact

Contact's Name Phone ( ) Relationship

Authorization to File Insurance

I certify that all the above information is correct. I authorize the release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits.

Signature Date