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Last: _____ First: _____ Middle: _____

Address: _____ Apt. #:_____

City: _____ State:_____ Zip: _____

Home #: _____ Work #:_____ Cell #: _____

S.S. #: _____ D.O.B.: _____ Sex: _____ Marital status: _____

Race: _____ Ethnicity: _____ Language: _____

Employer: _____ Occupation: _____

Referred by: _____ Family Dr.: _____

Pharmacy: _____

Emergency Contact Information:

Name: _____

Relation: _____ Number: _____

Policy Holder's Information: (Leave blank if patient is policy holder)

Last: _____ First: _____ Middle: _____

Address: _____ Apt. #:_____

City: _____ State:_____ Zip: _____

Home #: _____ Work #:_____ Cell #: _____

S.S. #: _____ D.O.B.: _____ Sex: _____ Marital status: _____

Employer: _____ Occupation: _____

Medical Information:
I authorize the person named below to receive information regarding my medical care:

Name: _____ Relation: _____

Agreement/Authorization Release:

I authorize the release of any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize my insurance company to pay directly to the doctor. If my insurance company does not pay, I understand that I will be responsible for payment.

Signature: _____ Date: _____