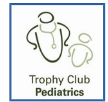

Patient Information

Last Name________________________ **First Name**____________________ **MI**____________________

DOB ______________________________ **Sex:** ☐ **Male** ☐ **Female** **SSN**____________________

Address__________________________ **City**__________________________ **State**____ **Zip**___________

Home Phone______________________ **Cell Phone**_____________________ **Work Phone**____________

Email Address___________________________________

Messages regarding my visit today, including test results, may be left or ☐ Home Phor ☐ Cell Phone

Race: ☐ White ☐ Black ☐ Hispanic ☐ Other __________________________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Preferred Language: ☐ English ☐ Spanish ☐ Other_______________________________

Mother's Name_______________________ Phone______________ Address __________________________

Father's Name:__________________________ Phone ______________ Address___________________________

Emergency Contact:____Phone_______________________

Responsible Party/Guarantor

Last Name_____________________ First Name__________________ MI___ DOB ________________

Address_____________________ City________________________ State____ Zip_____________

Home Phone___________________ SSN__________________ Relationship to Patient_____________

Insurance Information

Primary Insurance Company _______________**Policy Number**_____________ **Group Number**______________

Address__________________________ **City**__________________________ **State**____ **Zip**________________

Name of Insured_____________________ **DOB**____________________ **Relationship to Patient**______________

Secondary Insurance Company _______________**Policy Number**_____________ **Group Number**______________

Address__________________________ **City**__________________________ **State**____ **Zip**________________

Name of Insured_____________________ **DOB**____________________ **Relationship to Patient**______________

Verification of Information: I verify that the above information provided is true and correct to the best of my knowledge. I hereby authorize the facility to accept assignment of insurance benefits and I understand that I am responsible for coinsurance, copayments, and/or deductibles at the time of service< I understand that if my insurance is a non-contracted plan (out of network); the facility will courtesy file the claim for services rendered. In the event that I have no insurance coverage, I understand that the fees are due at the time of service. I understand that the facility has the right to withhold discharge paperwork and prescriptions in the event of nonpayment. I understand that the previous balances owed the facility will be requested at the time of registration.

X____ X____________________

Authorized Signature of Patient/ Guardian/ Accompanying Adult Date