

Who Referred You? How Did You Hear About Us? (please select and specify all that apply)

<input type="checkbox"/> Physician*	<input type="checkbox"/> Television _____	*Physician Name _____
<input type="checkbox"/> Self-referred	<input type="checkbox"/> Radio _____	Street Address _____
<input type="checkbox"/> Internet/Web Site	<input type="checkbox"/> Magazine _____	City _____ Phone _____
<input type="checkbox"/> Insurance Directory	<input type="checkbox"/> Newspaper _____	Specialty _____
<input type="checkbox"/> Friend/Other Patient	<input type="checkbox"/> Other _____	

Patient	
Name (Last, First, Middle Initial)	
Address	
City/State/Zip	
Social Security No.	
Home Phone	Work Phone
Date of Birth	Age
Marital Status	Marriage Date

Partner	
Name (Last, First, Middle Initial)	
Address	
City/State/Zip	
Social Security No.	
Home Phone	Work Phone
Date of Birth	Age
Marital Status	Marriage Date

Patient's Employment	
Company Name	Occupation
Address	
City/State/Zip	

Partner's Employment	
Company Name	Occupation
Address	
City/State/Zip	

Patient's Primary Insurance	
Insurance Company Name	
Address	
City/State/Zip	
Phone	
Policy Holder Name	
Policy No.	Group No.

Partner's Primary Insurance	
Insurance Company Name	
Address	
City/State/Zip	
Phone	
Policy Holder Name	
Policy No.	Group No.

Emergency Contact			
Name	Day Phone	Night Phone	Relationship

Authorizations	
<p>AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay non-covered services. I also realize that I am responsible for any other costs incurred while collecting my outstanding balance(s). I will pay you all costs of collection, including attorney's fees, up to the maximum permitted under applicable law, and other charges, if incurred.</p> <p>AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.</p>	

Patient	
Signed (Patient or Parent if Minor)	Date

Partner	
Signed (Patient or Parent if Minor)	Date