SECTION A

PATIENT INFORMATION:

Name:

Address:

City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Date of Birth:

E-Mail:

Marital Status: (circle one) SINGLE MARRIED OTHER

Gender: (circle one) MALE FEMALE

Employer or School (circle one) PART-TIME FULL-TIME

Is patient covered by insurance? NO YES - go to Section B

SECTION B

INSURED INFORMATION:

Patient relationship to Insured: (circle one) SELF SPOUSE CHILD

OTHER

If patient relationship to "insured" is other than "Self" please complete the following.

If the patient is insured, go directly to section C.

Name:

Address:

City: State: Zip:

Home Phone: Work Phone:

Date of Birth: Social Security #: - -

Marital Status: (circle one) SINGLE MARRIED OTHER

Employer or School (circle one) PART-TIME FULL-TIME

SECTION C

INSURANCE POLICY INFORMATION

Insurance Company:

Address:

City: State: Zip:

Plan Name:

Policy Number: Group #:

Is the patient covered by more than one insurance? (circle one) YES NO

SECTION D

If the patient is not covered by insurance:

I agree to make payment in full: (circle one) YES NO

Method of Payment: (circle one) CHECK CASH CREDIT CARD (if paying by credit - see below)

Credit Card #: Expiration Date:

Authorized Signature:

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