



**EMERGENCY CONTACT OUTSIDE OF HOME:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance**

Name of policy holder \_\_\_\_\_

Relationship \_\_\_\_\_

Policy holder birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Insurance company \_\_\_\_\_

Group # \_\_\_\_\_

Employee/cert. # \_\_\_\_\_

Insurance address \_\_\_\_\_

Deductible \_\_\_\_\_ Copay \_\_\_\_\_

**Additional Insurance**

Name of policy holder \_\_\_\_\_

Relationship \_\_\_\_\_

Policy holder birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Insurance company \_\_\_\_\_

Group # \_\_\_\_\_

Employee/cert. # \_\_\_\_\_

Insurance address \_\_\_\_\_

Deductible \_\_\_\_\_ Copay \_\_\_\_\_

**AUTHORIZATION AND RELEASE:**

*I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners.*

*I authorize and request my insurance company pay directly to the doctor insurance benefits otherwise payable to me.*

*I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of services rendered on my behalf or my dependents.*

\_\_\_\_\_  
Signature of patient (or parent of patient if minor)

\_\_\_\_\_  
Date

**LATE CHARGES:**

I realize that failure to keep this account current may result in us being unable to provide you additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.