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Patient Information:
Name: _____ DOB: _____ M / F
Home/Mailing Address: _____
City: _____ State: _____ Zip Code: _____

Parent's Information:
Name(s): _____
Home Phone: _____ Cell Phone: _____ Other Phone: _____

Emergency Contact Information:
Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

For Reminder Calls / Billing:
Phone Number: _____ Circle one: CALL / TEXT
Email Address: _____ Statements (circle one): EMAIL / MAIL

Patient Insurance Information:
Insurance Company: _____
Address: _____
Name of Subscriber: _____ Relationship: _____
SSN: _____ DOB: _____ Employer: _____
Insurance ID # _____ Group # _____

Assignment of Benefits and Financial Agreement

You are responsible for the deductible, share of cost, copayment at time of visit, and any costs not a benefit of your plan. If you do not have insurance, your payment is due at the time of services rendered. I authorize payment of medical benefits be made directly to the physician provider for services rendered. I authorize my doctor to release any medical or other information necessary to process claims with my insurance companies. I request payment of any government benefits to the party who accept assignment. I authorize use of information from this form to bill my insurance companies.
Guarantor Signature: _____ Date: _____

Authorization to Treat

I, _____ declare that I am the guardian on record for _____, and I consent to his/her treatment.

Signature: _____ Date: _____
Relationship to Patient: _____

Updated December 2015