## For Provider Use ONLY

Provider Name:
Diagnosis Code:

Referring Provider:
Authorization #:

COMPLETE AND ACCURATE INFORMATION IS REQUIRED

## PATIENT

Patient Name: _____

SS# _____

Address: _____

City: _____

State: _____ Zip: _____

Date of Birth: _____ Male: _____ Female: _____

Marital Status: _____

Home Phone: _____ Work Phone: _____

## RESPONSIBLE PARTY

Name & Address of person responsible for any balance not covered by insurance:

Same as Patient Other

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

## INSURANCE

Include copy of front & back of insurance card

Primary Insurance: _____

Insurance Address: _____
Phone: _____

City: _____ State: _____ Zip: _____

Subscriber #: _____
Group#: _____

Secondary Insurance: _____

Insurance Address: _____
Phone: _____

City: _____ State: _____ Zip: _____

Subscriber #: _____

Group#: _____

## SUBSCRIBER

Same as Patient  Same as Responsible Party  Other

Subscriber Name: _____
Date of Birth: _____ SS#: _____

Patient Relationship to subscriber: Self____  Spouse____  Child____

Other (specify) _____

Employer: _____
Phone: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize the Provider of service to furnish information to insurance carriers concerning my condition and treatment. I hereby assign to the provider all payments for medical services rendered to my dependents or myself. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature: _____
Date: _____