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Last Name	First Name	MI	
Sex ☐ Male ☐ Female			
Birth Date	Age	Soc. Sec. No.	
Home Address	City	State	Zip
Best Phone Number:			
Primary Care Physician	How did you hear about our practice?		
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Other			
Emergency contact name and phone number			
Is your current condition work-related and authorized as a worker's compensation care? ☐ Yes ☐ No			
Is your current condition due to a motor vehicle accident? ☐ Yes ☐ No			
Is your current condition due to a liability accident? ☐ Yes ☐ No			

Guarantor Information

Last Name	First Name	MI	
Birth Date	Soc. Sec. No	Sex ☐ Male ☐ Female	
Guarantor Home Address	City	State	Zip
Best Phone Number			

I hereby authorize this provider to release to any party responsible for payment, any information acquired in the course of medical examinations or treatment. I request that payment of authorized Medicare/Insurance benefits be made on my behalf to the party who accepts assignment for any services furnished to me by the supplier. I authorize this provider to release medical information about me to the Center of Medicare and Medicaid Services and/or my insurance company and its agents that is needed to determine these benefits or the benefits payable to related services.

I hereby authorize the provider to receive direct payment for the amount due to me in my pending claim for services rendered. I understand that I am financially responsible for charges not covered by my insurance and/or authorization. A photocopy of this authorization shall be considered as effect and valid as the original.

Signature: _____ Date: _____