

**PATIENT INFORMATION - PLEASE PRINT**

Patient Name:		Phone#:	Work Phone#:
Address:		City, State, Zip:	
Employer:	Occupation:	Student: Full-Time or Part-time (Circle one, if applicable)	
Date of Birth: ____/____/____	Sex: M or F	SS#: ____/____/____	Marital Status (Circle one) S M D W
Emergency Phone#:		Emergency Contact Name:	
Primary Care Physician (This is the physician you see for routine medical care)		Referring Physician (This is the physician that recommended that you contact us)	

**IMPORTANT:**  
Who else would you like to advise regarding your visit here (your allergist? Cardiologist? Rheumatologist?)

**BILLING INFORMATION - PLEASE PRINT**

Name of Responsible Party (if different from patient)			
Address:		City, State, Zip:	
Home Phone#:		Work Phone #:	
Employer:		SS#: ____/____/____	
Primary Insurance Carrier & Address:		Insured's Name:	
Policy#:	Group#:	Insured's Date of Birth: ____/____/____	
Patient's Relationship to Insured:			
Secondary Insurance Carrier & Address:		Insured's Name AND Employer:	
Policy#:	Group#:	Insured's Date of Birth: ____/____/____	
Patient's Relationship to Insured:			

\*\*\*\*\* IMPORTANT \*\*\*\*\*

If your health insurance requires a referral, you must have your valid referral available at the time of your visit. Payment for your copay is required at the time of the visit. For your convenience, we accept Mastercard and VISA. A service charge may be added to your account when the copayment is not made on the day of your visit.

**Please see Page 2 of this Form**

