

## Patient Demographics

Name: \_\_\_\_\_ Status: \_\_\_\_\_ SS#: \_\_\_\_\_  
Last First (SMWD)

Address: \_\_\_\_\_  
Street City Zip

D.O.B. \_\_\_\_\_ Sex: M F E-Mail: \_\_\_\_\_

Phone: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: Hispanic Other  
(circle one)

Alt. Phone: \_\_\_\_\_ Language: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### Insured's Information

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City Zip

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

**◆IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INDIVIDUAL COVERAGE◆**

Failing to comply with this information could result in you, the patient, being responsible for any costs incurred. Please remember that your insurance policy is a contract between you and your insurance company, and not between the insurance company and the doctor.

I authorize the release of any medical information necessary to process my claim and request payment of medical benefits.

Signature: \_\_\_\_\_ Witness: \_\_\_\_\_