



PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Date of Birth: _____ Age: _____ Marital Status: S M D W

Home Phone: _____ Work/Cell Phone: _____

Occupation: _____ Student Status: Full Time Part Time NA

Social Security Number: _____ Employer : _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

We require a copy of all insurance cards. Please present your insurance card to the receptionist.

Will you be using insurance with us? Y N Name of Insured Party: _____

Your relationship to the insured party: Self Spouse Dependent

Primary Insurance Company: _____

Primary Insurance Co. Address: _____

Subscriber ID #: _____ Group/Policy #: _____

Secondary Insurance Company: _____

Secondary Insurance Co. Address: _____

Subscriber ID #: _____ Group/Policy #: _____

ASSIGNMENT AND RELEASE

I hereby assign, transfer, and set over to Stephen C. Helton all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: _____ Date: _____