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MAKING THE CONNECTION

PATIENT APPLICATION FORM

(Please Print Clearly)

Today's Date:	**Who referred you?**		
CLIENT INFORMATION			
Last Name:	**First:**	**Middle:**	❍ Mr. ❍ Mrs ❍ Miss ❍ Ms.
Is this your legal name? ❍ Yes ❍ No			❍ Single ❍ Married
If not, what is your legal name?			❍ Divorced ❍ Separated
(Former name):			❍ Widow
Birth date:	**Age:**		❍ Male ❍ Female
Street address:	**P.O. box:**		
City:	**State:**		**ZIP Code:**
Home phone no.: ( )	**Cell phone no.:** ( )		
Social Security no.:		**Occupation:**	
Employer:		**Employer phone no.:** ( )	
Chose clinic because/referred to clinic by (Please check one box):			
Dr.			❍ Insurance plan ❍ Hospital
❍ Family ❍ Friend ❍ Close to home/work ❍ Yellow Pages ❍ Other			
Other family members seen here:			
INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:		**Birth date:**	
Address (if different):		**Home phone no.:** ( )	
Is this person a patient here? ❍ Yes ❍ No			
Occupation:		**Employer:**	
Employer address:		**Employer phone no.:** ( )	

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Is this patient covered by insurance? ❍ Yes ❍ No	
Please indicate primary insurance: ❍ Insurance ❍ Welfare (Please provide coupon) ❍ Other	
Subscriber's name:	**Subscriber's S.S. no.:**
Birth date:	**Group no.:**
Policy no.:	**Co-payment:** $
Patient's relationship to subscriber: ❍ Self ❍ Spouse ❍ Child ❍ Other	
Name of secondary insurance (if applicable):	
Subscriber's name:	
Group no.:	**Policy no.:**
Patient's relationship to subscriber: ❍ Self ❍ Spouse ❍ Child ❍ Other	
IN CASE OF EMERGENCY	
Name of local friend or relative (not living at same address):	
Relationship to patient:	
Home phone no.: ( )	**Work phone no.:** ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.	
Patient/Guardian signature	**Date**