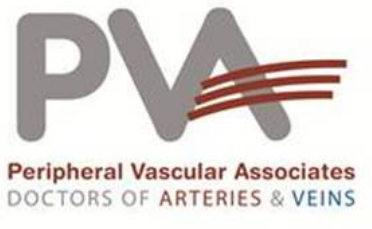

PATIENT INFORMATION

Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	Sex:
City:	Employer:
State: Zip:	Emergency Contact:
Home Phone#:	Emergency Phone:
Work Phone#:	Emergency Relationship:
Cell Phone#:	Patient Email:
Marital Status:	Primary Language:
PCP:	Referring MD:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security#:
Address Two:	Employer:
City:	Employer Address:
State: Zip:	Employer City:
Home Phone#:	Employer State:
Work Phone#:	Employer Zip:
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, when he accepts assignment.

_____ _____

Signed (Patient or Authorized person) **Date**