

Date: _____

Patient Information

NAME _____ SOC.SEC.# _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK/DAYTIME PHONE _____
SEX: __M__ F AGE _____ DATE OF BIRTH _____
MARRIED SINGLE SIGNIFICANT OTHER
PATIENT EMPLOYED BY _____ OCCUPATION _____
BUSINESS ADDRESS _____
EMERGENCY CONTACT / GUARDIAN _____ PHONE _____
REFERRING PHYSICIAN / PCP _____ PHONE _____
HOW DID YOU HEAR ABOUT THE CLINIC? _____
EMAIL ADDRESS _____

PRIMARY INSURANCE

SUBSCRIBER NAME _____ DATE OF BIRTH _____
RELATION TO PATIENT _____ SOC.SEC.# _____
ADDRESS (IF DIFFERENT FROM PATIENT) _____
CITY _____ STATE _____ ZIP _____
INSURANCE CO. _____ SUBSCRIBER'S EMPLOYER _____
INSURANCE ID # _____ GROUP # _____

ADDITIONAL PATIENT INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? __YES__ __NO__
SUBSCRIBER NAME _____ DATE OF BIRTH _____
RELATION TO PATIENT _____ SOC.SEC.# _____
INSURANCE CO. _____ SUBSCRIBER # _____
GROUP # _____ SUBSCRIBER'S EMPLOYER _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of insurance

and assign directly to Dr. Kate D'Archangel, ND all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

SIGNATURE OF INSURED/GUARDIAN

DATE