



Referring Physician: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Spouse: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Email Address: \_\_\_\_\_

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

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship of Emergency Contact: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Person Insured: \_\_\_\_\_

Insured Social Security Number: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Person Insured: \_\_\_\_\_

**Read the following information carefully and sign below:**

Medical care is based upon mutual understanding and confidence. You may discuss with the physician any questions regarding fees. Our billing service will assist in filing your insurance. **You, the patient, are responsible for your medical bill.** It is your responsibility to contact your insurance company prior to your office visit or procedure(s) to ensure your coverage benefits. CDHS will pre-certify your procedures. This pre-certification does not guarantee coverage or benefits.

**RELEASE OF INFORMATION REGARDING TEST/PROCEDURE RESULTS:**

Who may receive information regarding your Protected Health Information?

Spouse – Name and DOB: \_\_\_\_\_

Children – Names and DOB: \_\_\_\_\_

Significant Other/Friend – Name and DOB: \_\_\_\_\_

May we leave messages regarding test results on your voice mail? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please list all other physicians participating in your care:**

\_\_\_\_\_  
\_\_\_\_\_