PATIENT INFORMATION
PLEASE PRINT

Patient Name ________________________________ Date of Birth ____________________________

Address ____________________________ City ______________________ State______ Zip ________

Primary Phone ____________________________ Secondary Phone __________________________

Employer ________________________________ Employer Phone ___________________________

Sex Male / Female Social Security Number __________________________ Martial Status__________
Height ______________ Weight ______________

Responsible Party ___________________________________ Date of Birth ______________________

Social Security Number ______________________________ Employer __________________________

Emergency Contact Name ___________________________ Relationship ________________________

Phone ________________________________ Referred By __________________________

Primary Care Physician __________________________ Date of Last office visit ___________________

Pharmacy ______________________________ Pharmacy Phone _____________________________

Patients E-mail address ____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company ______________________________ Sex M / F

Member Name _______________________________ Member Date of Birth ____________________

Member Social Security Number __________________________ Relationship to patient ____________

ID # _______________________________________ Group # _____________________________

Employer ___________________________________ Policy Effective Date ______________________

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company ______________________________ Sex M / F

Member Name _______________________________ Member Date of Birth ____________________

Member Social Security Number __________________________ Relationship to patient ____________

ID # _______________________________________ Group # _____________________________

Employer ___________________________________ Policy Effective Date ______________________

Is this work related? _____ Date of injury ___________ Workers compensation Claim # ______________
Contact Name & Phone ___________________

I the undersigned certify that I (or my dependant) assign directly to Dr. Shari L. Kaminsky / Dr. Jerry M. Liddell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid 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 insurance submissions.

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Responsible Party Signature Relationship Date