Welcome to our office! **PLEASE ASSIST US BY PROVIDING THE FOLLOWING INFORMATION.**

PATIENT ACCT. # _____ DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____ SEX: _____

HOME ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

RACE: _____ ETHNICITY: _____ LANGUAGE: _____

REFERRED BY: _____ PHONE: _____

PATIENT OCCUPATION: _____ EMPLOYED BY: _____

WORK PHONE: _____

SOCIAL SECURITY NO.: _____ LIC.#: _____ MARITAL STATUS(SING., MARRIED, DIV.): _____

EMERGENCY CONTACT: _____
In Case of Emergency - Contact Name, Address, Phone.

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE BELOW.

NAME: _____ PHONE: _____

HOME ADDRESS: _____ SOCIAL SECURITY NO.: _____

_____

EMPLOYER: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY CARRIER: _____ PHONE NUMBER _____

ADDRESS _____

POLICY NUMBER _____ GROUP NUMBER _____ CO-PAY _____

INSURED NAME _____

SECONDARY CARRIER: _____ PHONE NUMBER _____

ADDRESS _____

POLICY NUMBER _____ GROUP NUMBER _____ CO-PAY _____

INSURED NAME _____

As patient, or as legal guardian of minor patient, I agree to pay for all services rendered. This office may bill my insurance carrier as needed. ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to CENTENNIAL MEDICAL GROUP. I am financially responsible for non-covered services. I authorize the physician to release any information necessary to process this request.

Signed _____