

**Patient Information**

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Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

Cell Phone \_\_\_\_\_ Pager # \_\_\_\_\_

eMail Address \_\_\_\_\_

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

Marital Status \_\_\_\_\_ Gender  Male  Female

Employer or School \_\_\_\_\_ Employment Status \_\_\_\_\_

Referred By \_\_\_\_\_ Field 1 \_\_\_\_\_

Field 2 \_\_\_\_\_ Field 3 \_\_\_\_\_

Is the patient covered by insurance?  Yes - Go to section II  
 No - Go to section V on back page of this form

**Section II - Insured Information**

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Patient Relationship to Insured:  Self  Spouse  Child  Other

If "Patient Relationship to insured" is other than "Self" please complete the following. If patient is the insured go directly to section III.

Insured's Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth    /    /    Social Security Number \_\_\_\_\_

Marital Status \_\_\_\_\_ Gender  Male  Female

Employer or School \_\_\_\_\_ Employment Status \_\_\_\_\_

**Section III - Insurance Policy Information**

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Medicare  Medicaid  ChampUS  ChampVA  Group Health Plan  FECA  Other

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Plan Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Is the patient covered by more than one insurance ?  Yes - Please complete Section 4 - Page 2  
 No - Please return this form to the Receptionist

(Over)

**Section IV - Secondary Insurance Policy Information**

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Medicare    Medicaid    ChampUS    ChampVA    Group Health Plan    FECA    Other

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Plan Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Section V - Billing Information**

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(Complete only if there is no insurance coverage.)

Who is responsible for charges for this patient.    Patient - Please return this form to the Receptionist.  
 Other - Please Complete the following information.

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth      /    /         Social Security Number \_\_\_\_\_

Marital Status \_\_\_\_\_      Gender    Male    Female

Employer or School \_\_\_\_\_      Employment Status \_\_\_\_\_