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 here by 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