LAST NAME _____ FIRST _____ MI _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ CELL PHONE # _____

SEX M F MARITAL STATUS _____ SS# _____

DOB _____ AGE _____ **E-MAIL** _____

EMPLOYER _____ PHONE #_____

SPOUSE NAME _____ SPOUSE BIRTHDATE _____

EMERGENCY CONTACT PERSON _____ PHONE # _____

RELATIONSHIP _____ E-MAIL _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

BEST NUMBER TO CONFIRM APPOINTMENT _____

BRING INSURANCE CARDS AND MEDICATIONS TO APPOINTMENT

I authorize any holder of medical or other information about me to release this information to the Social Security Administration, Health Care Financing Administration, my insurance company or its intermediaries or carriers, or the physician's office or to my attorney's or other doctor's office.

I authorize direct payment of medical benefits and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to the above-named physicians and surgeons. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I agree to pay all costs for collections, including reasonable attorney fees and court costs, in the event if becomes necessary to pursue the account for collection.

DATE _____ SIGNATURE _____

WITNESS _____

DO YOU HAVE A LIVING WILL? Y N