PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTH DATE	LANGUAGE	SEX

ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)	ETHNICITY

CITY, STATE ZIP	PHONE	SEC CITY, STATE ZIP	SECONDARY PHONE	RACE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	EMERGENCY CONTACT NAME	CONTACT PHONE

RESPONSIBLE PARTY INFORMATION (If Different Than Above)

NAME (Last, First Middle)	SSN#	BIRTH DATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	SECONDARY HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF THE INSURANCE COMPANY	POLICY#
NAME OF INSURED	GROUP#
ADDRESS OF INSURANCE COMPANY	CO-PAY AMOUNT
CITY, STATE ZIP	DEDUCTIBLE

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE

NAME OF THE INSURANCE COMPANY	POLICY#

NAME OF INSURED	SSN#	BIRTH DATE	GROUP#

ADDRESS OF INSURANCE COMPANY	CO-PAY AMOUNT
CITY, STATE ZIP	DEDUCTIBLE

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

______________________________ SIGNATURE OF PATIENT/GUARDIAN

______________________________ DATE