



PATIENT/INSURANCE INFORMATION

Account #: _____

Patient Name: _____
First Middle Last

Address: _____
Street City State Zip

Sex: M F Marital Status: S M W D Sep Date: _____ SS#: _____
(Circle) (Circle)

Home Phone #: _____ Cell Phone #: _____ E-Mail: _____

Emergency Phone #: _____ Other Phone #: _____
(Use Different phone # than Patient #)

Emergency Contact: _____ Relationship: _____
(Contact must not be living at same address as patient)

Employer's Telephone #: _____ Place of Employment: _____
(Of adult signing for permission to treat)

Employer's Address: _____
Street City State Zip

Drug Allergies: Yes () No () If yes, specify: _____

Primary Contract Holder Info: (Pt., Parent, or Spouse) Secondary Insurance or Spouse Info:

Name: _____

Name: _____

Date of Birth: _____

Date of Birth: _____

Contract and/or SS #: _____

Contract and/or SS #: _____

Group #: _____

Group #: _____

Employer: _____

Employer: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Insurance Company Information

I hereby authorize Complete Care Center to bill my insurance for any treatment rendered and to furnish medical information necessary to process my medical claims. I understand that I am responsible for any amounts not covered by insurance including co-pays and deductibles.

Note: If your insurance policy has a Master Medical Rider, we will bill them for you. You will receive the payment check in the mail. Therefore, you will be responsible to pay for ALL office visits, injections and durable medical supplies at the time of visit.. We accept insurance company checks, personal checks, and most credit cards to pay your accounts.

****PLEASE PRESENT ALL INSURANCE CARDS AND DRIVER'S LICENSE FOR COPYING.****

Patient or Parent (If Patient is a minor) Signature: _____ Date: _____

Relationship to Patient: _____

How did you find out about Complete Care Center? _____

For Insurance Information, be sure to get a copy of the Insurance Card.

2008