PATIENT INFORMATION

Today's Date:____________________________Referred By:____

First Name:________________________________MI:___________Last Name:________________________________

Address:_______________________________Apt:_____City:___________________State:__________Zip:________

Primary Phone:_____________________Type:_______ Secondary Phone:_____________________Type:________.

Third Phone:_____________________Type:_______ E-mail address:______________________________________

DOB:____________________SS#:________________________ Marital Status: S M D W Sex: M F

Employer Name:_______________________________________Occupation:_________________________________

Emp. Address:___________________________________City:____________________State:________Zip:_________

Name of Spouse/Parent:__________________________________Home Phone:_____________________________

Address:_______________________________Apt:_____City:___________________State:__________Zip:________

Spouse/Parent Employer:_________________________________Work Phone:_____________________________

Emergency Contact:______________________________Relation:______________Phone:_____________________

INSURANCE INFORMATION

Primary Insurance Plan:____

Circle One: HMO PPO Workers Comp Other____

Primary Care Physician:____________________Medical Group:______________Ins Phone:___________________

Insurance Address:________________________________City:__________________State:________Zip:_________

Name of Policyholder:______________________________DOB:___________Relation to Patient:________________

Insurance ID#:____________________Group #:_____________Policyholder SS#:____________________________

Secondary Insurance Plan:____

Circle One: HMO PPO Workers Comp Other____

Primary Care Physician:____________________Medical Group:______________Ins Phone:___________________

Insurance Address:________________________________City:__________________State:________Zip:_________

Name of Policyholder:______________________________DOB:___________Relation to Patient:________________

Insurance ID#:____________________Group #:_____________Policyholder SS#:____________________________

Assignment of Benefits, Eligibility Guarantee and Missed Appointment Policy

I request that payment of authorized insurance benefits be made on my behalf to Greg Bourque for any services rendered. I authorize Greg Bourque to release to my insurance plan and its agents any information needed to determine these benefits. I understand that if I am not eligible under the terms of my health plan, I am liable for all charges for services rendered. I also agree to pay in full for all non-covered services within 30 days of notification of non-coverage. I understand that Greg Bourque will require payment in full for any service if a cancellation is made within 24 hours of the scheduled appointment time.

____ ________________________________.

Signature of Patient or Parent/Guardian/Policyholder Date