Your Insurance is through what employment or association?_____

This insurance covers: DIAGNOSTIC, SCREENING/PREVENTION, BOTH TYPES OF COVERAGE
(please circle one)

I authorize and request payment of medical benefits from the above insurance company to my physician for services provided on this date. **Initials** _____

I certify that this is a copy of my current medical insurance card, and that to the best of my knowledge, this insurance is in effect as of this date.

I understand that if this insurance information is later found to be incorrect, I will be responsible for prompt payment of today's charges and that I will be refunded any balance due me once my correct insurance settles the claim for the visit. **Initials** _____

_____

Date of visit **Patient Name** **Patient Signature** **Date of Birth**

_____

Current Address **CIty** **State** **Zipcode**

_____

Home Phone **Work Phone** **Cell Phone**

May we leave messages for you about any test results _____ yes/no

Which phone number should we use _____Home _____Work? _____ Cell

In the future we may wish to contact you by email.
May we have your email address in anticipation of that eventuality? _____ yes/no

email: _____