

**Welcome to and thank you
for choosing our office.**

Today's Date _____

In order to serve you properly, we will need the following information.

First Name:	M.I.	Last Name	Birth date:	Sex: M F	Marital Status: S M W D
Street Address:			Home Phone #:		
City:		State:	Zip:	Work Phone #:	
Email address:			Cell Phone #:		
Social Security #:		D.L. #:			
Name of Employer:		Employer Address:		Occupation:	
For Patients under 18:					
Mother Full Name:		Father Full Name:			
Primary Insurance Company Name:		Subscriber # or ID #:		Group #:	
Subscriber Name:			Is current insurance through your employer? Yes No		
Do you have a Secondary Insurance Company? Y N			Subscriber # or ID #:		Group#
Name of Spouse:		Subscriber Date of Birth:		Spouse Social Security #:	
Name of Spouse's Employer:				Spouse's Work #:	
Name of person financially responsible for this account:					Phone #:
In case of an Emergency, please contact:		Relationship to patient:		Phone #:	
Primary Medical Doctor & phone #:			Endocrinologist & phone #:		
Please state the reason for your visit today:			Primary Pharmacy, Address, Phone #		
Who referred you to our office?					

By signing below, I authorize this office to release any information to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. I also authorize this office to give me reasonable and proper medical care by today's standards. I assign and request payment of medical benefits directly to the physician for services rendered.

Patient, Parent or Guardian signature: _____ **Date:** _____