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Name _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Telephone # Evening _____ Day _____

Birthdate _____ Age _____ Sex: M F

Social Security# _____ Email Address _____

Occupation _____

Parent's Name (if minor) _____

Name of Health Plan _____

Group# _____ ID# _____

Insured's Name (if other than self) _____ D.O.B. _____

Referred by _____

Allergies _____

Reason for Visit _____

I request that payment of authorized insurance benefits be made on my behalf to this office for any services furnished by the physician to me. I authorize any holder of medical information about me to release to health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____