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Name_____

Address_____Apt#_____

City_____State_____Zip_____

Telephone # Evening_____Day_____

Birthdate_____Age_____Sex: M F

SocialSecurity#_____EmailAddress_____

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:_____