

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** \_\_\_\_\_

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<b>Date of visit</b>	<b>Patient Name</b>	<b>Patient Signature</b>	<b>Date of Birth</b>
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<b>Current Address</b>	<b>City</b>	<b>State</b>	<b>Zipcode</b>
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<b>Home Phone</b>	<b>Work Phone</b>	<b>Cell Phone</b>
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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: \_\_\_\_\_