Patient Demographics

Name:	
Address :	
Address :	
City:	
State:	**Zip:**
Date of birth:	
SSN:	
Sex:	
Home Phone:	
Cell Phone:	
Email:	
Emergency Contact:	
Emergency Home phone:	
Emergency Work phone:	
Emergency Cell phone:	
Referring Dr:	
Family Dr:	
Cardiologist:	
Endocrinologist:	
Oncologist:	
Nephrologist:	
Neurologist:	
Rheumatologist:	

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my Provider, when he accepts assignment.

Authorization to Release Medical Information: I hereby authorize my Provider to release any information necessary for my course of treatment.

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Signed (patient or guardian if minor) Date