PATIENT INFORMATION

Name: Soc. Sec. #:

Last Name *First Name* *Middle Initial*

Birthdate: Age: Sex: M F ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address:

City *State* *Zipcode*

Cell Phone: Home Phone:

Email: ☐ Personal ☐ Business

Employer: Occupation: Business Phone:

Whom may we thank for referring you?:

EMERGENCY CONTACT INFORMATION

Contact Name: Cell Phone:

Home Phone: Business Phone:

Business Email:

PRIMARY INSURANCE INFORMATION

Subscriber Name: Subscriber Birthdate:

Relation to Patient: Soc. Sec #:

Address if Different from Patient:

Cell Phone: Email:

Employer: Occupation: Business Phone:

Insurance Company:

Group#: Subscriber#: Phone:

Dependents on Plan:

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with the company provided above and assign directly to **Dr. Jordan Andrews** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Jordan Andrews may use my health care information and may disclose such information with above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from signed date below.

Signature of Patient, Parent, Guardian or Personal Representative *Date*

Please Print Name of Patient, Parent, Guardian or Personal Representative *Relationship to Patient*