PATIENT NAME: _______________ FIRST _______________ MIDDLE _______________ LAST _______________ DATE OF BIRTH: _______________

SOCIAL SECURITY # _______________ DRIVER LICENSE # AND STATE: _______________ SEX: _______ MARITAL STATUS: _______________

MAILING ADDRESS: _______________ STREET NUMBER / NAME _______________ APT./HOUSE # _______________ CITY _______________ STATE _______________ ZIP

PHYSICAL ADDRESS IF DIFFERENT FROM MAILING ADDRESS (REQUIRED):

_______________ STREET NUMBER / NAME _______________ APT./HOUSE # _______________ CITY _______________ STATE _______________ ZIP

HOME PHONE: _______________ WORK PHONE: _______________ EMAIL ADDRESS: _______________

EMPLOYER NAME & ADDRESS: _______________ OCCUPATION: _______________

SPOUSE INFORMATION

NAME: _______________ FIRST _______________ MIDDLE _______________ LAST _______________ DATE OF BIRTH: _______________

SOCIAL SECURITY # _______________ OCCUPATION / EMPLOYER: _______________

EMERGENCY CONTACT (REQUIRED IN CASE OF EMERGENCY)

NAME: _______________ RELATIONSHIP: _______________ PHONE # _______________

ADDRESS: _______________ STREET _______________ CITY _______________ STATE _______________ ZIP _______________ PHONE # _______________

INSURANCE INFORMATION:

PRIMARY INSURANCE: _______________ ID # _______________ GROUP # _______________

ADDRESS: _______________ STREET _______________ CITY _______________ STATE _______________ ZIP _______________ PHONE # _______________

GUARANTOR/INSURED NAME: _______________ ID # _______________

ADDRESS: _______________ STREET _______________ CITY _______________ STATE _______________ ZIP _______________ PHONE # _______________

SECONDARY INSURANCE: _______________ ID # _______________ GROUP # _______________

ADDRESS: _______________ STREET _______________ CITY _______________ STATE _______________ ZIP _______________ PHONE # _______________

GUARANTOR/INSURED NAME: _______________ ID # _______________

ADDRESS: _______________ STREET _______________ CITY _______________ STATE _______________ ZIP _______________ PHONE # _______________

IF PATIENT IS A MINOR, NAME OF RESPONSIBLE GUARDIAN: _______________

ADDRESS & PHONE # OF GUARDIAN: _______________

THIS IS TO VERIFY MY CONSENT FOR THE TREATMENT OF: _______________

SIGNATURE OF GUARDIAN: **X** _______________ RELATIONSHIP: _______________ DATE: _______________

I hereby authorize Harbir Makin, MD and his staff to release any information to my insurance carriers and referring doctors concerning my illness and treatment and authorize assignment of all claims and payments. I also accept full responsibility for all the fees incurred by myself and dependents regardless of insurance coverage.

I also acknowledge the receipt of a copy of the Notice of Privacy Practices and also acknowledge that if collections become necessary to pay my account then I or my guardian wil become responsible for the collection agency fees and expenses.

X _______________ Signature of Patient / Legal Guardian

_______________ Date