Patient Information

Name_____ Date of Birth____/____/____ SSN_____

Address_____ City_____ State____ Zip_____

Phone (Check Preferred Contact Number)

☐**(H)**_____ ☐**(W)** _____ ☐**(C)** _____

E-Mail Address_____ Sex: ☐ Male ☐ Female

Preferred Language_____ Ethnicity_____ Race_____

Marital Status: Single___Married___Other___ Student: Yes___ No___ Veteran: Yes ___ No___

Employer_____ Occupation_____

Insurance Information-*_Bring all Insurance cards to your appointment, with a photo ID_*

Also, Patient is responsible to get electronic referral from PCP to Specialist, if required.

Primary Care Physician_____ - City & State_____

Referring Physician_____ - City & State_____

Insurance:_____- Subscribers ID:_____

Emergency Contact:

Name _____ Relationship_____ Phone_____

Insurance Information: I authorize Pact, L.L.C. to submit claims and to receive payments for medical services provided to me. The assignment remains in effect until revoked by me in writing. I also authorize Pact, L.L.C. to release all information necessary to my insurance company to secure payment for services rendered. I understand that I am fiscally responsible for all charges incurred whether or not covered by my insurance.

_____ _____

Signature of Patient/Guardian Date