



RESPONSIBLE PARTY FOR PATIENT (GUARANTOR)			
Last Name:		First Name:	
Street Address:	City:	State:	Zip:
Home Phone:		Cell Phone:	
Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other (Specify) <input type="checkbox"/>			
EMPLOYER INFORMATION			
If patient is a child please fill in with parent's information		Mom	Dad
Employer:			
Address:		Work Phone:	
ALTERNATE MAILING ADDRESS (if different from Guarantor)			
Street Address:	City:	State:	Zip:
PATIENT INFORMATION			
First Name:	Middle Initial:	Last Name:	
Date of Birth (patient):	Date of Birth (insured):	M <input type="checkbox"/>	F <input type="checkbox"/>
Name of Physician/Person Referring you to us:			
Name of Primary Care Physician:			
Social Security Number:			
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Other <input type="checkbox"/>			
Have you seen any other doctors within MNS? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If so, which doctor?			
How did you hear about our practice?			
Phone Book <input type="checkbox"/> Friend <input type="checkbox"/> Other Advertisement <input type="checkbox"/> Referred by Physician <input type="checkbox"/>			
Other: _____			

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INSURANCE INFORMATION

If you have your insurance card with you we will need to make a photocopy for our records. If you have a co-pay please make check payable to the physician you are seeing.

Policy Holder's Name:		Policy Holder's Date of Birth:		
Primary Insurance:				
Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other (Specify) <input type="checkbox"/>				
Policy #		Group #		
Policy Holder's Name:		Policy Holder's Date of Birth:		
Secondary Insurance:				
Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other (Specify) <input type="checkbox"/>				
Policy #		Group #		
EMERGENCY CONTACT INFORMATION				
Last Name:		First Name:	Phone:	
Mailing Address:	City:		State:	Zip:
Relationship to Patient (relative, friend, neighbor, etc.)				

It is the patient's responsibility to obtain any necessary referrals or pre-authorizations from their insurer or primary care doctor. Failure to verify the need for a referral with your insurer may result in a denial of payment by the insurance company.

Patients without insurance coverage are required to pay for services at the time of their visit. All patients are required to pay co-pays or other cost shares at the time of service. Requests for special reports may require payment in advance.

Fees will vary based on the doctor's specialty and the length and complexity of the visit.

Signature

Date