

Name \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_  
Street City State Zip Code

Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security Number \_\_\_\_\_

Home Phone(\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone(\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone(\_\_\_\_)\_\_\_\_-\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone(\_\_\_\_)\_\_\_\_-\_\_\_\_\_

**SPOUSE INFORMATION**

Name \_\_\_\_\_ Social Security \_\_\_\_\_  
Date of Birth \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_  
Occupation \_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

**PRIMARY INSURANCE**

Name of Insurance \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_  
Policy Holder's Date of Birth \_\_\_/\_\_\_/\_\_\_ Policy Holder's Social Security \_\_\_\_\_  
Policy Holder's Employer \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Insurance \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_  
Policy Holder's Date of Birth \_\_\_/\_\_\_/\_\_\_ Policy Holder's Social Security \_\_\_\_\_  
Policy Holder's Employer \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Phone Number(\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip Code

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Glass or Dr. Levine and any treating physician to furnish any and all information with respect to any illness or injury copies of all hospital or medical records to any individual, review agency, or corporation in any way responsible for the payment of charges incurred and, in the event of transfer, to any subsequent health care provider.

THIS INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENERAL DISEASE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFIFIENCY SYNDROME (AIDS), INITIAL HERE THAT YOU UNDERSTAND THESE TERMS \_\_\_\_\_.

ASSIGNMENT OF BENEFITS: I hereby authorize direct to the above physician and/or hospital, of the benefits otherwise payable to me, but not to exceed the physician's and/or hospital regular charges. I understand I am financially responsible for charges not covered by this assignment. I certify that the above information in support of this claim is true and correct.

Date \_\_\_/\_\_\_/\_\_\_ Patient Signature \_\_\_\_\_