



Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status: Married/Single/Divorced/Widowed (Circle One)

Primary Phone: \_\_\_\_\_ Circle One: Home Work Cell

Secondary Phone: \_\_\_\_\_ Circle One: Home Work Cell

Email Address: \_\_\_\_\_

Preferred Contact Method: E-mail/Telephone (Circle One)

Language Preference: English/Spanish Other: \_\_\_\_\_

Race: Caucasian/African American/Hispanic/Asian/Native American Other: \_\_\_\_\_

**Guarantor Information: (Insurance Policy Holder)**

**Primary** Insurance: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

**Secondary** Insurance: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(Circle One) Home Work Cell

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(Circle One) Home Work Cell

**Assignment and Release:** I understand that I am financially responsible for charges incurred for services rendered. Full payment is expected at the time services are rendered. As a courtesy to you, we will submit your medical claim to your insurance company. I hereby authorize, and assign direct payment of my medical insurance benefits to Midwest Regional Health Services, LLC. I also authorize my medical provider to release my information requested by my medical insurance company.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date