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