PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Date	Social Security #	Birthdate
Name (Last Name) (First Name) (Middle Initial)		Sex ☐ M ☐ F ☐ Transgender / Age
Address (City) (State) (Zip Code)		
Home Phone	Cell Phone	Email

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered

Race	Ethnicity	Preferred Language	Preferred method of contact *(Check all that apply)*
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian ☐ White ☐ Other Pacific Islander ☐ Other	☐ Hispanic ☐ Non-Hispanic		☐ Home Phone ☐ Work Phone ☐ Cell Phone / SMS (text) ☐ Email ☐ patient portal

Patient Employer / School	Occupation
Employer / School Address	Employer / School Phone
In case of emergency, who should be notified?	Phone Number
Name of Primary Care Physician	Name of Referring Physician *(if different from PCP)*

PRIMARY INSURANCE (If this is not filled out you will be billed for all visits)

Insurance Company	
Subscriber #	Group #
Person Responsible for Account (Last Name) (First Name) (Middle Initial)	
Relationship to Patient / Birthdate / Social Security #	
Address (if different from patient) (City) (State) (Zip Code)	Phone
Person Responsible – Employed by	Occupation
Business Address (City) (State) (Zip Code)	Business Phone
Names of other dependents covered under this plan	Copay $

SECONDARY OR ADDITIONAL INSURANCE

Insurance Company		
Subscriber #	Group #	
Person Responsible for Account (Last Name) (First Name) (Middle Initial)		
Relationship to Patient	Birthdate	Social Security #

ASSIGNMENT AND RELEASE

I certify that I and my dependents have insurance coverage with _____ and assign directly to Center for Rheumatic
Name of Insurance Company
Diseases and Osteoporosis, P.A. all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature of all insurance admissions. The Center for Rheumatic Diseases and Osteoporosis, P.A. may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent includes my authorization to release medical information to my primary care physician and/or consulting physicians to assist with continuity of my healthcare. This release will remain in effect until I cancel this release in writing.

Signature of Patient, Parent, Guardian, or Personal Representative	**Date**
Please print name:	**Relationship to Patient:**