INS CARD COPIED _____ ARB SIGNED _____

PATIENT INFORMATION

PLEASE PRINT AND COMPLETE ALL INFORMATION

NAME _____ MAIDEN NAME _____

E-MAIL ADDRESS _____

HOW DO YOU WISH TO BE ADDRESSED? _____ SSN _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK # _____ CELL # _____

AGE _____ DATE OF BIRTH _____ DRIVER'S LICENSE _____

PLACE OF BIRTH _____

EMPLOYER NAME _____ PHONE # _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
YOUR OCCUPATION _____ FULL TIME / PART TIME (PLEASE CIRCLE ONE)

SIGNIFICANT OTHER NAME _____ DOB _____ SSN _____
EMPLOYER _____ PHONE _____ OCCUPATION _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENTS EMPLOYER (IF UNDER 18 OR A STUDENT) _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ ID# _____ GROUP# _____

POLICY HOLDER _____ DOB _____ SSN _____

RELATIONSHIP TO PATIENT: (SELF/SPOUSE/PARENT)

SECONDARY INSURANCE _____ ID# _____ GROUP# _____

POLICY HOLDER _____ DOB _____ SSN _____

RELATIONSHIP TO PATIENT: (SELF / SPOUSE / PARENT)

LOCAL EMERGENY CONTACT **(NOT AT THE SAME ADDRESS)**

NAME _____ PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

I HEREBY GIVE LIFETIME AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO: DR. REYNARD AND ANY ASSISTING PHYSICIAN FOR SERVICES RENDERED. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. IN THE EVENT OF DEFAULT, I AGREE TO PAY COLLECTION FEES AND REASONABLE ATTORNEY FEES. I HEREBY AUTHORIZE THIS PROVIDER TO RELEASE INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. A COPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL. I REALIZE I WILL BE RESPONSIBLE FOR A $25.00 FEE IF I REQUEST A COPY OF MY CHART FOR MYSELF OR FOR USE BY ANOTHER PHYSICIAN. THERE WILL ALSO BE A CHARGE FOR COMPLETION OF ALL DISABILITY FORMS, MEDICAL LETTERS, EMPLOYER FORMS.

SIGNATURE _____ DATE _____