



Patient Administrative Information

Patient Name: _____ Gender: M F

Date of Birth: _____ Social Security Number: _____

Address: _____
Street/mailling address City State Zip

Phone: Home() _____ Cell() _____ email _____

Employer Name: _____ Work Phone: () _____

Employer Address: _____

Referred By: _____ Marital Status: M S D W

Responsible Party Information (if different from patient)

Name: _____ DOB: _____ SSN: _____

Address: _____

Phone: Home() _____ Work() _____ Employer: _____

Do you have a living will? _____ Do you have a power of attorney? _____
(If yes, please provide copy)

Preferred Pharmacy: _____ Location: _____

Emergency Contact: _____ Relationship: _____

Phone: Home() _____ Cell() _____ Work() _____

- PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED •
• INSURANCE CARD MUST BE PRESENTED AT TIME OF SERVICE •

Insurance Subscriber Information: Name: _____ DOB: _____

Address: _____ Phone: _____

Employer: _____ Work Phone: _____

Patient's relationship to subscriber: _____

Please read carefully before signing:

I hereby authorize Access Healthcare to release information acquired during the course of my examination and treatment to any third party carrier as necessary to secure payment of any benefits due. I hereby assign payment of said benefits to include Medicare and Medigap directly to Access Healthcare for any medical procedures performed. I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

Signature: _____ Date: _____