Patient Name_____
Last First Middle

Address_____

Date of birth_____**Age**_____**Sex**_____**SSN**_____

Phone: PRIMARY# _____**Work** _____**Other**_____

E-Mail Address_____

Family Doctor_____ **Spouse's Name**_____

Patient Employer_____ **Occupation**_____

Referred by: Advertisement _____ **Website** _____

Doctor (Name) _____**Family Friend (Name)** _____

In case of an emergency Notify _____**Relationship** _____**Phone** _____

Pharmacy Name _____ **Pharmacy Phone**_____

WE SEND ALL SPECIMENS TO AURORA DIAGNOSTIC LABORATORIES
(Patient is responsible for any residual charges)

***Would you like to receive billing statements from our office via E-Mail*?** **YES_____NO_____**

1. **Primary Insurance Co Name**_____
Member/Policy #_____**Group#**_____
Ins Co Billing Address _____
Subscriber (Policy Holder) Name_____
Patient being seen today is what relationship to the subscriber? Self _____Spouse _____Child _____Other_____
Subscriber's Address (if different from above) _____
Subscriber's Social Security #_____ **Subscriber's Date of Birth** _____
Subscriber's Occupation _____ **Subscriber's Employer**_____
Address of Employer_____ **Phone#**_____

2. **Secondary Insurance Co Name**_____
Member/Policy #_____ **Group#**_____
Ins Co Billing Address _____
Subscriber (Policy Holder) Name_____
Patient being seen today is what relationship to the subscriber? Self _____Spouse _____Child _____Other_____
Subscriber's Address (if different from above) _____
Subscriber's Social Security #_____ **Subscriber's Date of Birth**_____
Subscriber's Occupation _____ **Subscriber's Employer**_____
Address of Employer_____ **Phone#**_____

Payment is required for all services at the time they are rendered. We accept payment in the form of cash, check or credit card. In the event of hospitalization or major procedures, our office will file with the appropriate insurance you will be asked to pay any unmet deductible, non-covered services and co-payments. Your signature below signifies your understanding and willingness to comply with this policy.

SIGNATURE**_____DATE**_____