

Date: \_\_\_\_\_

**PATIENT INFORMATION**

Account # \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Last Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ Race / Ethnicity \_\_\_\_\_  
City, State Zip \_\_\_\_\_ Language \_\_\_\_\_  
Employer \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
City, State Zip \_\_\_\_\_ Cell / Voicemail \_\_\_\_\_  
Occupation \_\_\_\_\_ Email \_\_\_\_\_  
Referred by \_\_\_\_\_

A DETAILED MESSAGE MAY BE LEFT AT:  HOME  WORK  CELL/VM  PLEASE DON'T LEAVE A MESSAGE

**RESPONSIBLE PARTY**

Last Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City, State Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_ Policy Subscriber \_\_\_\_\_  
Address \_\_\_\_\_ Insured Policy ID \_\_\_\_\_  
City, State Zip \_\_\_\_\_ Group # \_\_\_\_\_  
Telephone \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Effective Dates \_\_\_\_\_ -- \_\_\_\_\_ Patient Relation to subscriber \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy Subscriber \_\_\_\_\_  
Address \_\_\_\_\_ Insured Policy ID \_\_\_\_\_  
City, State Zip \_\_\_\_\_ Group # \_\_\_\_\_  
Telephone \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Effective Dates \_\_\_\_\_ -- \_\_\_\_\_ Patient Relation to subscriber \_\_\_\_\_

**PARTNER'S / SPOUSE'S INFORMATION**

Partner's / Spouse's Name \_\_\_\_\_ Cell / Voicemail \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Home \_\_\_\_\_  
Relationship \_\_\_\_\_ Cell / Voicemail \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Frumovitz, Matsunaga, Daly, Ross, Thordarson, Vogel & Klevens, M.D.s to release any medical information necessary to process insurance claims relating to the medical care rendered by Frumovitz, Matsunaga, Daly, Ross, Thordarson, Vogel & Klevens, M.D.s. I authorize payments of medical benefits to Frumovitz, Matsunaga, Daly, Ross, Thordarson, Vogel & Klevens, M.D.s for any medical care rendered to myself or my dependents. I understand that I am responsible for any amounts not covered by my insurance. A service charge of 1.5% will be charged on the unpaid principle balance on all accounts not paid within 60 days of date of service.

I also acknowledge that there will be a minimum charge of \$25 for failed appointments.

Signature \_\_\_\_\_ Date \_\_\_\_\_