



PROVIDENCE Clinics

Welcome To Our Office

Date: _____

Please Check:

New Patient

Update

Referred By _____

Patient Information - Please Print

Name _____ Sex Male Female
Last First M.I.

Birth Date _____ Social Security # _____ Age _____

Address _____ City _____ Zip _____

Employer _____ Home Phone _____
Company Address

Occupation _____ Work Phone _____

Guarantor _____ Cell Phone _____
Person responsible for the bill

Guarantor Address _____ Home Phone _____

Employer _____ Work Phone _____
Company Address

Marital status of patient: Single Married Divorced Widowed

Spouse/Parent/Guardian _____ Relationship to patient _____

Spouse/Parent/Guardian Address _____ Home Phone _____

Employer _____ Work Phone _____
Company Address

Insurance Information

Primary Insurance _____

Policy Number _____ Group Number _____

Subscriber _____ Sex Male Female Birth Date _____
Person who has the insurance

Social Security # _____ Relationship to patient _____

Employer _____

Secondary Insurance _____

Policy Number _____ Group Number _____

Subscriber _____ Sex Male Female Birth Date _____

Social Security # _____ Relationship to patient _____

Employer _____

Emergency Contacts

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

**Consent and Authorization for Release of Information
Assignment of Benefits**

I hereby give my consent for medical treatment upon _____ (Name of Patient).

I hereby authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to me or to the party who accepts assignment.

Signature _____ Date _____
Parent/Patient/Guardian/Authorized Person