reiter, hill
johnson + nevin

How did you hear about us?
(Please Circle)

Google Facebook Yelp Referral Other: _____

Patient ID: _____

Patient Information

First Name:	**M.I.:**	**Last Name:**	
Email address:		**Date of Birth:** ____/____/_____ Age:	
Address:	**Apt. #**	**Marital Status:** ☐ **S** ☐ **M** ☐ **D** ☐ **W**	
City:			
State:	**Zip:**		
Phone(h):	**Phone(c):**	**Phone(w):**	**Ext:**
Employer:		**Occupation:**	
Work Address:		**SSN:**	

Race	**Ethnicity**	**Preferred Language**
☐ American Indian/ Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline to answer	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to answer	☐ English ☐ Spanish ☐ Other (please specify):_____

Emergency Contact

Name: Phone Number:

Pharmacy Information	**Preferred Method of Contact**
Preferred Pharmacy Name: **Pharmacy Zip:** **Pharmacy Phone:**	☐ Phone ☐ Mail ☐ E-Mail

Referring Physician: **Referring Physician Phone Number:**

Primary Insurance

Insurance Company Name:	**Policy Number:**	**Group Number:**
Insurance Company Address:		**Date Effective:**
Subscriber's Name:	**Relationship to Patient (If Self, leave this section blank) :**	
Subscriber's Address:	**Subscriber's SSN:**	
Subscriber's DOB:	**Sex:** ☐ **M** ☐ **F**	

Secondary Insurance

Insurance Company Name:	**Policy Number:**	**Group Number:**
Insurance Company Address:		**Date Effective:**
Subscriber's Name:	**Relationship to Patient (If Self, leave this section blank) :**	
Subscriber's Address:	**Subscriber's SSN:**	
Subscriber's DOB:	**Sex:** ☐ **M** ☐ **F**	

Authorization Acknowledgement

AUTHORIZATION TO RELEASE INFORMATION: I hereby confirm that all the information provided by me is accurate. Any false information will result in my responsibility for any costs incurred due to fraudulent information. I authorize the release of any medical or other information necessary to process this insurance claim.	**Signature(Patient or Parent if minor)**	**DATE**
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her service a described, realizing that I am responsible to pay non-covered services.	**Signature**	**DATE**
AUTHORIZATION TO TREAT A MINOR (UNDER AGE OF 18). In the event of an emergency and I cannot be contacted, I give my permission to the doctors or the persons under their instruction, to treat my child in their office or hospital as required by the event of that emergency situation.	**Signature**	**DATE**