Patient's Last Name :______________________ First Name : _________________________ MI :____

Address :____

City :______________________________ State Code :__________ Zip code :____________

Referral Dr.:__________________________ Sex (M/F) :_________ Status: _____S M D W

Birth Date :_____/____/______ Social Sec. :________/________/____________

Home Phone : (____) _________________ Work Phone : (___)__________________________

Name of Emerg. Contact Person :______________________________ Contact No. : (___) _________________________

Patient's Email: ____________________________ Patient's Cell :(___) _________________________

PRIMARY INSURANCE COVERAGE

Company :___________________________

Insured Name :___________________________

Relationship :_____________ DOB: ____/___/___

Co-Pay Amount :_______________________

Policy Number :_______________________

Group Number :_______________________

Employer :______________________

SECONDARY INSURANCE COVERAGE

Company:__________________________________

Insured Name :____________________________

Relationship :__________ DOB: ___/___/____

Co-Pay Amount :___________________________

Policy :___________________________

Group Number :____________________________

Employer :____________________________

GUARANTOR INFORMATION

Guarantor Name :____

Address :____

City :___________________ State Code :___________ Zip Code : ________________________

Telephone # : (____) ____________________ Relationship :__________________________________

PATIENTS' AUTHORIZATION

I authorize SIMMONS-O'BRIEN & ORLINSKY, LLC to apply for benefits on my behalf for services rendered by SIMMONS-O'BRIEN & ORLINSKY, LLC. I request payment, only from the insurances that SIMMONS-O'BRIEN & ORLINSKY, LLC participates with, be made directly to the practice. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time, in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when statement is rendered.

Signature of Subscriber or Beneficiary ____________________________ **Date** _______________