Patient's Last Name: _____ First Name: _____ MI : _____

Address:_____ City: _____

State:_____ Zip: _____ Assigned Gender at Birth (M/F):_____

Referring Dr.:_____ Pronouns: he/him, she/her, they/them

Birth Date: ____/____/_____ Marital Status: S M D W S Work Phone:(___)_____

Emerg Contact Name: _____ Home Phone:(___)_____

Emerg Contact Phone: _____ Cell Phone: (___)_____

Relationship to Patient:_____ Patient Email: _____

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 Number:_____

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:_____

Print Name:_____