

**PATIENT INFORMATION**

Patient's last Name	First Name	Middle	Marital Status (Circle One) <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other <input type="checkbox"/> Married/Partnered <input type="checkbox"/> Widowed		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Birth Date: ____/____/____	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address	City	State	Zip	Phone: (   )	
Occupation:	Employer:	Work Phone:			
Referred By: <input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Website <input type="checkbox"/> Other					

**INSURANCE INFORMATION**

Person responsible for Bill: <input type="checkbox"/> (Check if self)	Address (if Different)		
Subscriber's Name	Social Security #:	Birth Date: ____/____/____	
Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	Insurance Company Name:		
Policy #:	Group #:	Co-payment (If known): \$	
Name of Secondary Insurance company (if applicable):			Subscriber Name:
Policy #:	Group #:	Birth Date of subscriber: ____/____/____	

**IN CASE OF EMERGENCY**

Name of Local Friend or Relative:	Relationship:	Home #: (   )	Work #: (   )
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The above information is true to the best of my knowledge. I authorize The International Health Clinic to provide either my family member or myself with reasonable and proper medical care. I authorize the insurance company or any third party payer to direct any benefits to this office, should they accept assignment on my claim. I also authorize I.H.C and my insurance companies to release any information required to process my medical claims. I understand that I.H.C has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to I.H.C, I agree to forward to the clinic all health insurance and other third party payments that I receive for services rendered to me immediately upon receipt. **I understand that I am financially responsible for my account at I.H.C if my insurance does not cover services rendered to me for any reason.**

X \_\_\_\_\_

**Patient Signature**

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**Date**