

PATIENT INFORMATION		The Shell Center
Acct No.:	() Adult () Child	Today's Date:
Name:	() Male () Female	Date of Birth:
Address:		SSN:
City:	State/Zip:	Marital Status:
Home Phone:	Work Phone:	
Emergency Contact:	Pharmacy:	
Emergency Phone:	Pharmacy Phone:	
Occupation:	Primary Care Physician:	
Employer:	Phone:	
Employer Address:	Referring Physician:	
	Phone:	

PERSON RESPONSIBLE FOR BILL () Self () Spouse () Parent () Guardian () Other		
Name:	Employer:	Date of Birth:
Address:		SSN:
City:	State/Zip:	
Home Phone:	Work Phone:	

INSURANCE INFORMATION	
Company:	Co-pay/co-insurance:
Address:	Deductible:
	Group #:
Phone Number:	ID #:

AUTO CLAIMS	
Claim Number:	Insurance Company:
Date of Accident:	Phone Number:
State Accident Occurred:	Address:

Please READ and SIGN the following:

I hereby authorize payment of BENEFITS due me to the physician for all services rendered. I hereby authorize the physician/provider to RELEASE any information required to process my insurance claim form. I certify to the ACCURACY of the above information. I understand that I am FINANCIALLY RESPONSIBLE for all charges, regardless of any insurance coverage. A copy of this signature is as valid as the original.

Signature

Date