



**PATIENT INFORMATION:**

How did you hear about us? (Circle) TV, Radio, Direct Mail, Newspaper, Friend/Family, Physician, Website, or Health Fair

Referred by: \_\_\_\_\_ Personal Clinician: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
First Middle Last Preferred

Patient's Mailing Address: \_\_\_\_\_  
Number and Street Apt/Lot City State Zip

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Male  Female Race: \_\_\_\_\_ Language: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Best Way to contact you: Phone  Email  Is this visit due to a work-related incident? Yes  No

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ School: \_\_\_\_\_

**PAYMENT INFORMATION:**

Person Responsible for Payment/bill: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_  
Number and Street Apt/Lot City State Zip Main Phone

Relationship to Patient: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Best Way to Contact Individual: Phone  Mail  Email Address: \_\_\_\_\_

**INSURANCE INFORMATION:**

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_  
Number and Street Apt/Lot City State Zip

Relationship to Patient: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Main Phone: \_\_\_\_\_ 2nd Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

2nd Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**PATIENT'S CONTACTS:**

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_  
Name Relationship Main Phone 2nd Phone

Primary Caregiver: \_\_\_\_\_  
Name Relationship Main Phone 2nd Phone

Emergency Contact: \_\_\_\_\_  
Name Relationship Main Phone 2nd Phone

All professional services rendered are the financial responsibility of the patient. Payment is expected upon the provision of services. For insured patients, we are pleased to assist in the filing of your insurance claims. \*By signing below, I hereby consent to my insurance carrier releasing all necessary information to Affinity Health Group, LLC regarding the status of my claims. Further, I hereby authorize Affinity Health Group, LLC to furnish information to my insurance carrier concerning my medical history, illness and treatments. Further, I authorize my insurance carrier to pay directly to Affinity Health Group, LLC all benefits to which I and/or my dependents may be eligible for the provision of healthcare services.

**I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS ABOVE**

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**CONSENT:**

I hereby voluntarily give consent for the necessary medical treatment for the above named patient.

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date