Patient Information

Last Name_____ First Name_____
Middle Int._____

Address_____

City_____ State_____ Zip_____

Home# (____)_____

Cell# (____)_____

Work# (____)_____

DOB_____ SSN_____ (refuse mark X)_____

Sex: _____Male_____Female

Married_____ Single_____ Separated_____ Divorced_____
Widowed_____

Minor_____ Partnered for _____ years

Employer_____

Employer address_____

Referring Doctor_____

Primary Doctor_____

In case of emergency who should be notified?_____
Phone_____

Insurance Information *(PLEASE FILL OUT ONLY IF INSURANCE IS NOT IN YOUR NAME)*

Person Responsible for insurance_____

DOB_____SSN_____ (refuse mark X)_____

Phone_____

Address (if different from
patients)_____

City_____ State_____

Zip_____

Additional Insurance

Is patient covered by additional Insurance? _____Yes _____NO

Subscriber
Name_____

Relation to Patient_____

DOB_____SSN_____(refuse mark X)_____

Insurance Company_____

Assignment and Release

I certify that I, and/or my dependents(s), have coverage with
_____ and
(Name of Insurance Company)

Assign directly to **Dr. Kakitelashvili** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

Signature of Patient, Parent,
Guardian_____

Date_____