|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last Name: |  | First Name: |  | MI: |  |
|  |  |  |  |  |  |  |
| Gender: | [ ] Male [ ] Female | Date of Birth: |  / /  | Social Security# |  - - |
|  |  |  |  |  |  |  |
| Referring Physician: |  | Marital Status | [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Domestic Partner |
|  |  |  |  |  |  |  |  |
| Address: |  | City:  | State: |  | Zip Code: |  |
|  |  |  |  |  |  |  |  |
| Telephone Numbers | Primary: |  |  | Secondary: |  |
|  |  |  |  |  |  |  |  |
| Employer’s Name: |  | Occupation: |  | Phone: |  |
|  |  |  |  |  |  |  |  |
| Race: | [ ] Asian [ ] Native Hawaiian [ ] Other Pacific Islander [ ] Black/African American  |
|  | [ ] American Indian/Alaskan Native [ ] White [ ] More than one Race [ ] Decline to answer  |
|  |  |  |  |  |  |  |  |
| Ethnicity | [ ] Not Hispanic/Latino [ ] Hispanic/Latino [ ] Decline to answer |  |  |  |
|  |  |  |  |  |  |  |  |
| Language | [ ] English [ ] Spanish [ ] Other: | E-Mail: |  |
|  |  |  |  |  |  |  |  |
| **Insurance** |
| Insurance card(s) or proof of insurance must be presented at the time of service |
| **Primary Insurance:** |  |
| \*\*If you are not the policy holder, please complete the following information\*\* |
| Policy Holder’s Name: |  | Date of Birth: |  | Policy Number: |  |
| **Secondary Insurance:** |  |
| \*\*If you are not the policy holder, please complete the following information\*\* |
| Policy Holder’s Name: |  | Date of Birth: |  | Policy Number: |  |
| **Assignment and Authorization of Benefits for Patients with Insurance** |
| I hereby state that the above information is true and correct to the best of my knowledge. I hereby assign, transfer, and set over to Fredericksburg Clinic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance. |
|  |  |  |  |  |  |  |  |
| Signature of Patient or Personal Representative |  | Date |
| **\*\*\*Financial acknowledgement for Private Pay Patients or Patients without Insurance\*\*\*** |
| Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service. |
|  |  |  |  |  |  |  |  |
| Signature of Patient or Personal Representative |  | Date |

