Patient Information **PRINT CLEARLY**

Patient Name: _____ Date: _____

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Wk#: _____ ext____

Email Address: _____

Birth Date: _____ Sex: M___ F___ **Marital Status:** S__ M__ D__ W__ SS# _____

Preferred language: _____ **Race:** _____ **Ethnicity:** _____

Guardian: _____ DOB _____ SS# _____
(If patient is a minor)
Address: _____ City: _____ ST: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Wk#: _____ ext____

Referred by: _____ **Dr/Friend/Website/Web Search/other** _____

Emergency Contact: _____ Relationship: _____
(Not living with you)
Home Phone #: _____ Cell #: _____ Wk#: _____ ext____

Employer: _____ Phone #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Insurance
Primary
Name: _____ Phone #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Insured: _____ Relation: _____ DOB _____ SS# _____

Policy #: _____ Group #: _____ Claim #: _____

Adjuster: _____ Phone #: _____ ext: _____

Secondary
Name: _____ Phone #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Insured: _____ Relation: _____ DOB _____ SS# _____

Policy #: _____ Group #: _____ Claim #: _____

Adjuster: _____ Phone #: _____ ext: _____

Lawson C Richter, MD will make every effort to bill all available insurance for you with the condition that the complete and correct information has been provided by you at the time of the initial visit. If all insurance is not disclosed at the time of the initial visit then you waive the right to use any available medical and/or health insurance for service provider to you.
I certify the above information is true and correct to the best of my knowledge. I will notify office of any changes in health status of the above information. I hereby authorize my insurance benefits be paid directly to the physician and I understand that I am financially responsible for any/all non-covered services. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees, interest attorney fees and court cost that may be added to my account in order to recover monies due to **Lawson C Richter, MD**. I also authorize the physician and/or the insurance/s to release any and all information required in processing my claims.

Patient/Guardian Signature _____ **Date** _____