Please fill out and return at appointment along with photo I.D. and insurance card(s).

**Deductibles and co-pays due at time of visit.**

**Please Print with Black Ink**

Date ____________________

~Patient Information~

Name ____________________ Soc Sec # ____________________
Last First MI

Address ____________________ Home Phone ____________________

City ______ State ______ Zip ______ Cell Number ____________________

Sex M F (please circle) Age ______ Birth date ______ Marital Status Mar Sin Wid Sep Div (please circle one)

Patient Employed by ____________________ Occupation ____________________

Business Address ____________________ Business Phone ____________________

Referred by ____________________ Email Address ____________________

In case of emergency, whom should we notify? ____________________ Phone ____________________

Race:

White African American Hispanic Other Decline to Specify

Ethnicity:

Hispanic Non-Hispanic

How would you like to be contacted:

Phone E-mail Letter Patient Portal

Consent to download your medication from pharmacy Yes No

Pharmacy name ______ Address ______ Phone# ______

~Primary Insurance~

Person Responsible for Account ____________________
Last First MI

Relation to Patient ______ Birth date ______ Soc Sec # ______

Address (if different from patient's) ____________________ Phone ____________________

City ______ State ______ Zip ______

Person Responsible Employed by ____________________ Occupation ____________________

Business Address ____________________ Phone ____________________

Insurance Company ____________________

Contract # ____________________

Assignment & Release~

I, the undersigned, certify that I (or my dependent) have insurance coverage with ____________________ above named Insurance Company(ies) and assign directly to Breast Care Specialists AMC and Drs. Sockrider and Mook- Broadwell 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____________________

Responsible Party Signature Relationship Date