



Date of first appointment ____/____/____ Marital Status: S M D W Sex: Male Female
 Name: _____ Birthdate: ____/____/____ Age: ____
 Last First Middle Initial Month Day Year

Address: _____ Apt # _____
 Street City State Zip Social Security # ____-____-____

Contact Info: Home ____-____-____ Cell ____-____-____ Email _____

Emergency Contact: _____ Phone: ____-____-____

Employer: _____ Employer Address: _____

Employer Phone: ____-____-____ Please Check if this applies: Do NOT call at work

Spouse or Parent Name: _____ Birthdate: ____/____/____ SS# ____-____-____

Primary Care Physician: _____ Phone: ____-____-____

Address: _____ Fax: ____-____-____

Referred here by: (check one)
 Self Family Friend (name): _____ Referring Doctor: _____

Referring Doctor Address: _____ Phone: ____-____-____

Preferred Pharmacy: _____ Address: _____ Phone: ____-____-____

Insurance Information

Primary health insurance company name and address: _____

Policy Holder: _____ Relationship to Patient: _____

ID/Policy Number: _____ Group Number: _____

Secondary health insurance company name and address: _____

Policy Holder: _____ Relationship to Patient: _____

ID/Policy Number: _____ Group Number: _____

I request that payment of authorized benefits be made on my behalf directly to S'eclairer for any services furnished to me by S'eclairer. To the extent permitted by law, I authorize any holder of medical or other information about me to release to my insurance carrier, and their agents any information to determine these benefits for related services. I permit a copy of this authorization to be used in place of the original.

I, _____, have received a copy of S'eclairer's Notice of Privacy Practices.

Policy Holder: _____ Signature: _____ Date: ____/____/____

RELEASE AND ASSIGNMENT

- I authorize the use of this form or a copy of it on ALL my insurance submissions
- I authorize release of information to my insurance companies for purposes of utilization and quality assurance reviews.
- I authorize the release of any information necessary to process my insurance claims and assign and request payment to my provider.
- I authorize payment directly to S'eclairer, pc.
- I will ENDORSE any checks payable to me that should have been paid directly to S'eclairer, pc.
- I agree that payment for services provided remain my responsibility in the even my insurance does not reimburse for the services rendered by S'eclairer, pc.
- I have received a copy of the above named provider's Privacy Policy.

Signature: _____ Date: ____/____/____