Patient Information

Name:	
Mailing Address:	
DOB: / /	**SS #: - -**
City: State: Zip:	**Home Phone: ( ) -**
Cell Phone: ( ) -	**Alt Phone: ( ) -**
Employers Name & Address:	
	Employers Phone: ( ) -
Emergency Contact:	
Phone ( ) -	**Relationship:**

Responsible Party or Parent of Minor Child

Fathers Name:	
DOB: / /	**SS #: - -**
Employers Name & Address:	
	Employers Phone: ( ) -
Home Phone: ( ) -	**Cell Phone: ( ) -**
Mothers Name:	
DOB: / /	**SS #: - -**
Employers Name & Address:	
	Employers Phone: ( ) -
Home Phone: ( ) -	**Cell Phone: ( ) -**

Insurance Information

Primary Insurance Company:		
Address:		**Phone: ( ) -**
I.D. # :	**Group #:**	**Copay $**
Policy Holders Name:		
DOB: / /	**SS #: - -**	**Relationship:**
Secondary Insurance Company:		
Address:		**Phone ( ) -**
I.D. # :	**Group #:**	**Copay: $**
Policy Holders Name:		
DOB: / /	**SS #: - -**	**Relationship:**

'I hereby authorize payment directly to **Salida Family Medicine/David M. Arnett, M.D., P.C.** of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance for services rendured on my behalf of my dependents. I authorize the above providers to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.'

Signature:	**Date: / /**