PATIENT INFORMATION

❑ Mrs. ❑ Ms. ❑ Miss	**Last Name:** .	**First Name**: .	**Middle:**
Referring Provider:		**Primary Care Provider**:	
Birth Date:	Age:	**Social Security #**:	

Marital Status (circle): Single, Married, Divorced, Separated, Widowed, Other

What is the Best Way for Us to Call You?	**Cell Phone:**	**Home phone #**:
Address:	**Work Phone:**	
Email:	**Occupation**:	**Employer**:

INSURANCE INFORMATION

Insurance coverage? ❑Yes ❑ No

Person Responsible for Bill:	Address:	**Phone**: Type (circle): (h) (c) (w)

Name of **Primary Insurance**:	**Subscriber's name:**	**Group #:**	**Policy #:**
Subscribers Employer: .	**Subscriber's Birth Date**:	**Copay**:	
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		
Name of **Secondary Insurance**:	**Subscriber's name:**	**Group #:**	**Policy #:**
Subscriber's Employer: . .	**Subscriber's Birth Date**:	**Copay**:	
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		

IN CASE OF EMERGENCY

Name of Emergency Contact	Relationship:	Phone no.: ( )	Type of phone

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Yamaki's office or my insurance company to release any information required to process my claims.

Patient/Guardian signature: **Date**