TODAY'S DATE		EMAIL ADDRESS**		
LAST NAME** FIRST**		MIDDLE	MR. MISS MRS. MS	MARITAL STATUS SINGLE / MAR / DIV / WID
SOCIAL SECURITY#**	DATE OF BIRTH**	AGE	SEX (CIRCLE)** MALE FEMALE	CELL PHONE#
STREET ADDRESS**		CITY**		STATE & ZIP**
EMPLOYER**		HOME PHONE#**		WORK PHONE #**
EMPLOYER ADDRESS**		CITY**		STATE & ZIP**

PRIMARY INSURANCE INFORMATION

INS. COMPANY NAME**		INSURANCE ADDRESS	
ID#**		GROUP #**	COPAY AMOUNT**
SUBSCRIBER NAME**	DATE OF BIRTH**	EMPLOYER**	SOCIAL SECURITY #**
RELATIONSHIP TO PATIENT (CIRCLE)**	SELF PARENT	SPOUSE	OTHER

SECONDARY INSURANCE INFORMATION

INS COMPANY NAME		INSURANCE ADDRESS	
ID#**		GROUP #**	COPAY AMOUNT**
SUBSCRIBER NAME**	DATE OF BIRTH**	EMPLOYER**	SOCIAL SECURITY #**
RELATIONSHHIP TO PATIENT (CIRCLE ONE)	SELF PARENT	SPOUSE	OTHER

EMERGENCY CONTACT INFORMATION

NAME	HOME PHONE #	WORK PHONE #
RELATIONSHIP TO PATIENT**		

I UNDERSTAND THE ABOVE INFORMATION TO BE TRUE TO THE BEST OF MY KNOWLEDGE.IFI CANNOT PROVIDE THE INFO, I WILL BE BILLED.I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE.

I AUTHORIZE AFM AND MY INSURANCE COMPANY TO RELEASE ANY MEDICAL INFORMATION REQUIRED TO PROCESS MY CLAIMS. I AM AWARE OF THE HIPPA REGULATION,AND A COPY CAN BE PROVIDED TO ME AT MY REQUEST.

SIGNATURE OF PATIENT OR GUARDIAN**	DATE**