## PATIENT INFORMATION

NAME, FIRST_____M.I._____ LAST_____
MARITAL STATUS:_____
SOC.SEC.#_____-_____-_____ EMPLOYER:_____
DATE OF BIRTH:_____/_____/_____ GENDER:_____
HOME ADDRESS:_____
_____

EMAIL ADDRESS:_____

PHONE #: _____ _____ _____
**CIRCLE PREFERRED #:** HOME# WORK # MOBILE#

IS IT OK TO LEAVE A DETAILED MESSAGE? **YES/NO**

MAY RELEASE MEDICAL INFO. TO: (names of family members/guardian)_____
_____,_____,_____,_____

EMERGENCY CONTACT:_____PHONE #:_____
SPOUSE:_____PHONE #:_____
CARETAKER:_____PHONE #:_____

SEASONAL ADDRESS:(IF APPLICABLE)_____
_____

**GUARANTOR: PERSON FINANCIALLY RESPONSIBLE (a.k.a. Guarantor) IF DIFFERENT THAN PATIENT**

GUARANTOR NAME:_____
GUARANTOR ADDRESS:_____
_____
INSURANCE:_____
SUBSCRIBER NAME:_____D.O.B._____/_____/_____
(SUBSCRIBER IS PRIMARY PERSON WHO HOLDS INSURANCE IF DIFFERENT THAN SELF)

RELATIONSHIP TO SUBSCRIBER:_____
(EX. SPOUSE, CHILD, OTHER)

**ASSIGNMENT OF BENEFITS:**
I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSSARY TO PROCESS ALL CLAIMS AND REQUEST THAT ALL MEDICAL BENEFITS BE PAID DIRECTLY TO DR. LIM. I UNDERSTAND THAT ALL SERVICES RENDERED MAY NOT BE COVERED IN FULL AND AGREE TO BE PERSONALLY RESPONSIBLE FOR BALANCES DUE. IN THE EVENT OF DEFAULT, I AGREE TO PAY ALL COSTS OF COLLECTION AND REASONABLE ATTORNEY FEES. I HEREBY AUTHORIZE DR. LIM TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I GIVE CONSENT TO HAVE PHOTOGRAPHS TAKEN FOR MY RECORD. I FURTHER AGREE THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL..

**PLEASE SIGN HERE:**_____ **DATE:**_____/_____/_____