Dr. Elizabeth Cummins

Patient Information

Name	Home Phone ( )
Address	Work Phone ( )
City,State,Zip	Birthdate Age
Employed: Full-time Part-time Homemaker Student	Social Security #
Employer (or School)	Marital Status M S D W
Employer's Addr	Nearest Relative (Not living with you)
City,State,Zip	Relative's Phone # ( )

Responsible Party or Spouse Information (skip if same as above) (required for minors)

Name	Home Phone ( )
Address	Work Phone ( )
City,State,Zip	Birthdate
Employer Name	Social Security #
Employer Addr	Relationship to Patient
Employer City,State,Zip	Referring Physician

Insurance information

Ins Co Name	Insured's Name
ID # Group #	Insured's Social Sec #
Claims Address	Insured's Employer
City,State,Zip	Insured's Birthdate
Phone # ( )	Relationship to Patient

Secondary insurance (if applicable)

Ins Co Name	Insured's Name
ID # Group #	Insured's Social Sec #
Claims Address	Insured's Employer
City,State,Zip	Insured's Birthdate
Phone # ( )	Relationship to Patient

I authorize the release of any medical information required to determine benefits or facilitate insurance reimbursement. This authorization shall remain valid until written notice is given by me revoking the release. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature_____________________________________ Date_________________
(or responsible party if patient is a minor)

How did you hear about us? ____