PATIENT INFORMATION (Please Print & Complete Entire Form) Today's Date ___/___/___

Name_____
Last *First* *M.I.*
Mailing Address_____
City *State* *Zip*
Preferred Phone(cell/home)_____ Work Phone_____ SS#_____
Area Code *Area Code*
Employer Name _____ Address, City, State, Zip _____

Date of Birth ____/____/____ Age_____ Sex_____ Ethnicity/ Race_____ Martial Status _____

Drivers License #_____(Please provide Drivers License to Receptionist for copying) State_____

*We are now offering appointment reminders through Text and/or Email. If you wish to participate in this service please provide us with your Cell phone # and/or Email:_____

PARENT OR RESPONSIBLE PARTY (if different from the patient)

Name_____SS#_____
Last *First* *M.I.*
Mailing Address_____
City *State* *Zip*
Home Phone_____ Work Phone_____Date of Birth ____/____/____ Sex_____
Area Code *Area Code*

INSURANCE INFORMATION (Please present insurance card at time of check in). ***Note: We do not participate, bill or accept , Medicaid, Soonercare or Oklahoma Health "High Risk Pool", Tricare 2nd to Medicare only. (Please complete All Entries)***
*****All Info is required in order to process claim properly***

Primary
Insurance Name_____
Ins. Address_____
Name of Insured_____
Insured's ID# _____
Group # _____ Date of Birth_____
Employer Name _____
Employer Address _____
Employer Phone _____
Relationship of patient to the Insured _____
Guarantor Social Sec#_____
Copay Amount _____

Secondary
Insurance Name_____
Ins. Address_____
Name of Insured_____
Insured's ID#_____
Group # _____Date of Birth _____
Employer Name _____
Employer Address _____
Employer Phone _____
Relationship of patient to the Insured _____
Social Security#_____
Copay Amount_____

I authorize (BTHD) to leave message or discuss medical account and medical care Y or N (Please Circle)

Authorized to discuss medical & account information with:_____Relation_____

In case of Emergency, who should be notified? _____Relation_____Phone_____

Other family members that are patients _____

Doctor Referred by: _____Phone_____

Primary Care Physician _____Phone_____

ASSIGNMENT AND RELEASE: By signing this form, I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. **Note: We Do Not Offer Payment Plans.* I also authorize the physician to release any information required in the processing of this claim and all future claims. *If my account is sent to a collection agency, I agree to pay all collection and attorney fees.* I also authorize the release of medical information of my care to referring physician, or consultants if needed and as necessary.

Responsible Party Signature (Required/no initials) _____ ***Date*** _____