

## INITIAL INFORMATION

Client's Name \_\_\_\_\_ Date \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**If you do not want messages left on any of these telephone numbers, please circle the number.**

Email Address: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Social Security # \_\_\_\_\_ Referred By \_\_\_\_\_

Employer \_\_\_\_\_

### PRIMARY CARE PHYSICIAN INFORMATION:

Name \_\_\_\_\_

Telephone \_\_\_\_\_

Would you like me to mail your PCP a summary of your diagnosis and treatment? \_\_\_Yes \_\_\_No

**Emergency Contact** \_\_\_\_\_  
Name Telephone Number

### INSURANCE INFORMATION:

Name of Company \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

Regarding the Policy Holder:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Please read the following statements, circle yes or no, and sign below:**

1. I understand that I am responsible for all charges for services provided to me by Dr. Vogan, regardless of insurance reimbursement: \_\_\_Yes \_\_\_No
2. I agree to pay all fees owed by me at the time of my visit: \_\_\_Yes \_\_\_No
3. I agree to pay the full fee for appointments not cancelled 24 hours in advance: \_\_\_Yes \_\_\_No
4. I give Dr. Vogan permission to release information obtained from me that is necessary to authorize treatment and obtain reimbursement from my insurance plan: \_\_\_Yes \_\_\_No
5. I assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Dr. Vogan: \_\_\_Yes \_\_\_No

Client's Signature \_\_\_\_\_

Date \_\_\_\_\_