



Patient Information

Name (last, first): _____ Date of Birth: _____
 Street Address: _____ SS#: _____
 _____ Home Phone: _____
 City, State, Zip: _____ Work Phone: _____
 E-Mail Address: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Sex: Male Female Marital Status: Married Single Divorced
 Widowed Separated

Employer's Name: _____ Phone: _____

Relationship to Insured: Self Spouse Child Other

Health Insurance Information(primary)

Health Insurance Name: _____ Address: _____

ID#: _____ Group#: _____ Plan Name or #: _____

Name of Insured: _____ Birth Date: _____ SS#: _____

Relationship to Insured: Self Spouse Child Other

Health Insurance Information(secondary)

Health Insurance Name: _____ Address: _____

ID#: _____ Group#: _____ Plan Name or #: _____

Name of Insured: _____ Birth Date: _____ SS#: _____

Relationship to Insured: Self Spouse Child Other

Financial Responsibility (Person responsible for Patient Named Above)

I authorize the release of any information necessary to process medical claims for the patient named above and authorize that payment of benefits for these claims be made to CanThera. Also, I agree to promptly pay for any services not covered by my insurance and or determined by my insurance company to be my responsibility (i.e., deductibles, co-payments and any charges for services and/or laboratory tests not covered or deemed "Not Reasonable and Necessary).

 Signature of Guarantor Date

Relationship to Insured: Self Spouse Child Other

Referring Physician: _____ Phone: _____

How did you hear about us? Doctor Internet Friend Other