



Please Fill Out Completely

Patient's Last Name				First Name				MI
Social Security Number		Date of Birth	Age	Cell Phone		E-mail Address		
Address (Street, Route, Apt. No., etc.)					City	State	Zip Code	
Home Phone		Marital Status		Sex	Driver's License Number		Employed By	
Business Phone	Is it okay to call you at work? <input type="radio"/> YES <input type="radio"/> NO		Employer's Address		City	State	Zip Code	

Guarantor Information

Name		Address		City	State	Zip Code	
Home Phone		Social Security Number		Date of Birth		Relationship to Patient	
Employed by				Business Phone			
Employer's Address				City	State	Zip Code	
Emergency Contact (Friend or relative not at Patient's address who can get a message to you.)					Daytime Phone		
Referring Physician			Pharmacy		Pharmacy Phone		
How did you hear about us?							

Insurance Information

Primary Health Insurance Company _____
 Ins ID# _____ Policy # _____
 Insured Name _____ Date of Birth _____ Sex _____ Rel _____

Secondary Health Insurance Company _____
 Ins# ID _____ Policy # _____
 Insured Name _____ Date of Birth _____ Sex _____ Rel _____

List Any Persons to Whom You Will Allow Access Of Your Medical Records

Name _____ Relationship to Patient _____
 Name _____ Relationship to Patient _____

***The doctor's service is provided directly to you and not to an insurance company. Therefore, we cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, we will file any and all claims as authorized by you and will assist in making collections from the insurance company and then will credit all such collections to your account. By signing below, I hereby authorize SJMG,LLC to furnish information concerning my present medical care to the insurance company that is listed above.*

*I direct the insurer to Pj without equivocation, directly to SJMG,LLC, all benefits due them as a result of the claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of this authorization will be as valid as the original.***

Signature of Patient _____ Date _____

I acknowledge that I have been given access to the 'Notice of Privacy Practices' for SJMG,LLC, .

Signature of Patient _____ Date _____