Quality Care With a Personal Touch
350 N. Main Street, Suite #100
Chelsea, MI
Office: 734-433-1500
Fax: 734-433-1400

Name ____________________ Date of Birth __________ Sex __________

Address ________________________________ Apt __________

City ____________________ State ______ Zip Code __________

Home Phone ____________________ Cell Phone ____________________

Email Address ________________________________

Social Security Number ____________________ Marital Status __________

Employer ____________________ Occupation ____________________

Work Phone ____________________

Primary Insurance ________________________________

Contract Number ____________________ Group # ____________________

Relationship to Primary Insurance Member
(Circle One)

Self Spouse/Partner Child/Dependent

Primary Card Holder's Full Name ____________________ DOB __________

Secondary Insurance ________________________________

Contract Number ____________________ Group # ____________________

Relationship to Primary Insurance Member
(Circle One)

Self Spouse/Partner Child/Dependent

Secondary Card Holder's Full Name: ____________________ DOB __________

Emergency Contact ____________________ Phone ____________________

I agree that the above information is correct. I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to the doctor all payments for medical services rendered.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE

Signature ________________________________ Date ____________________