

**Client Information (Please Print)**

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: M F  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_)\_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_\_  
Who referred you to the office? \_\_\_\_\_ Cell Phone (\_\_\_\_)\_\_\_\_\_  
Family or Primary Care Physician \_\_\_\_\_ E-mail \_\_\_\_\_

**Responsible Party (If same as client, please skip to next section)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F  
Address \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_\_

**Insurance Information**

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_  
Group No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Subscriber No. \_\_\_\_\_ Subscriber No. \_\_\_\_\_  
If work related, claim # \_\_\_\_\_ Policyholder name \_\_\_\_\_  
Ins. Co. Phone No (\_\_\_\_) \_\_\_\_\_ Ins. Co. Phone No (\_\_\_\_) \_\_\_\_\_

**Emergency Contact (not residing with you)**

Name \_\_\_\_\_ Home Phone (\_\_\_\_)\_\_\_\_\_  
Address \_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_\_  
Relationship to patient \_\_\_\_\_

**Assignment of Insurance Benefits**

I hereby assign payment of authorized benefits to which I am entitled to be made directly to Dr. Juretic for services she provides to me. I authorize any holder of medical information about me to release any information needed to determine if these benefits are payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges not made by insurance. I hereby authorize Dr. Juretic to release all information necessary to secure payment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_