WEB IZ LABEL

PATIENT INFORMATION (PLEASE PRINT – USE ONLY INK):

Patient Name: (Last) ____________________________ (First) __________________________ (Middle):____________

Social Security: ______________________ ☐ Female ☐ Male Date of Birth: _________________ Age: _______

Home Address: _______________________________ City:_______________ State________ Zip Code__________

Primary Phone: ___________________ May we text you? ☐ Yes ☐ No Email: _____________________________

PRIMARY CARE PHYSICIAN NAME/PHONE NUMBER (Cigna Members Only): __________________________________

DO YOU HAVE HEALTH INSURANCE? ☐ Yes ☐ No Do you have other Insurance besides **MEDICAID?** ☐ Yes ☐ No

RESPONSIBLE PARTY: (Complete this section only if the patient is a minor): ☐ Parent ☐ Guardian

(Last Name): _____________________________ (First): _____________________________ (Middle): __________________

☐ Female ☐ Male Date of Birth: __________________________ Primary Phone: _________________________

Home Address: ___________________________________ City:________________ State____________ Zip Code________

☐ Student ☐ Employed ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer _______________________________________ Occupation: __________________________________

PRIMARY INSURANCE: Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Co. _______________________________ Id # ___________________________ Group #: _________________

Name of Insured: ____________________________ Date of Birth: ___________________ Social Security: ____________

Employer: _______________________________________ Occupation: ___________________________________

☐ Same As Above (If different, please complete):

Home Address: ____ City: ______________ State_______ Zip Code__________

SECONDARY INSURANCE: Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Co. _______________________________ Id # ___________________________ Group #: _________________

Name of Insured: ____________________________ Date of Birth: ___________________ Social Security: ____________

Employer: _______________________________________ Occupation: ___________________________________

☐ Same As Above (If different, please complete):

Home Address: ____ City: ______________ State_______ Zip Code__________

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I certify that the above information is correct to the best of my knowledge. I hereby authorize SNHD to furnish the insured's insurance company all information which said insurance company may request concerning the present services rendered. I assign SNHD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. I will notify SNHD in writing of any change in my or my minor child's insurance coverage. This authorization shall continue and be in full force and effect until revoked in writing by me.

______________________________________ ____________ ____________

Patient (or Responsible Party) Signature **Date** **SNHD Initials**