



DATE: \_\_\_\_\_ (OPTIONAL) E-MAIL \_\_\_\_\_

**(PATIENT'S INFORMATION)**

PATIENTS NAME: (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SOCIAL SECURITY # : \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SEX: \_\_\_\_\_ RACE: \_\_\_\_\_

**(RESPONSIBLE PARTY INFORMATION)**

NAME: (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_ HOME NUMBER: \_\_\_\_\_ WORK: \_\_\_\_\_

**(PRIMARY INSURANCE SUBSCRIBER INFORMATION)**

NAME: (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ S.S.# \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP: \_\_\_\_\_

**(SECONDARY INSURANCE SUBSCRIBER INFORMATION)**

NAME: (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ S.S.# \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP: \_\_\_\_\_

EMERGENCY CONTACT AND/OR CELL \_\_\_\_\_

**REFERRAL SOURCE: (PLEASE CHECK ONE)**

- WORD OF MOUTH
- PRINT ADS
- WEBSITE
- SPEAKING ENGAGEMENTS
- OTHER MEDIA
- REFERRING DOCTOR
- PREVIOUS PATIENT OF DR. DODDS
- PREVIOUS PATIENT OF DR. MCCORQUODALE

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED INCLUDING NON-COVERED SERVICES FROM MY INSURANCE COMPANY, ALSO THE REMAINING BALANCE AFTER PAYMENT FROM MY INSURANCE BENEFITS. I AUTHORIZE PAYMENT FOR PROFESSIONAL SERVICES RENDERED AND ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.**

**SIGN \_\_\_\_\_ DATE \_\_\_\_\_**  
**(PARENT OR GUARDIAN)**

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