Quality Care with a Personal Touch
350 N. Main Street, Suite #100
Chelsea, MI 48118
Office: 734-433-1500
Fax: 734-433-1400

Name ________________________________ Date of Birth _______ Sex ___________________

Address ____ Apt _________

City __________________________________ State _________ Zip _________

Home Phone __________________________ Cell Phone ______________________________________

Email Address ____ Marital Status _________

Social Security Number ____________________________

Employer _____________________________ Occupation ______________________________________

Work Phone ____

Primary Insurance ____

Contract Number ____________________________ Group # ____________________________

Relationship to Primary Insurance Member

Self Spouse/Partner Child/Dependent

Primary Card Holder's Full Name DOB

Secondary Insurance ____

Contract Number ____________________________ Group # ____________________________

Relationship to Secondary Insurance Member

Self Spouse/Partner Child/Dependent

Primary 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 ____________________________