O&O Alpan, LLC

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(Please Print)

Today's date:	**Referring/Primary Care Physician:**

PATIENT INFORMATION

Patient's last name	**First**	**Middle Initial**

Birth Date	**Age**	**Marital status (circle one)**	**Sex**	
/ /		**Single / Mar / Div / Sep / Wid**	❑ **Male**	❑ **Female**

Street address	**City**	**State**	**Zip**

Primary Phone	**Secondary Phone**	**Email Address**
( )	( )	

Race:	❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑ White/Caucasian ❑ Other ___________________ ❑ Decline To Answer
Ethnicity:	❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Other _____________ ❑ Decline to Answer
Language:	❑ English ❑ Spanish ❑ Other ____________________ ❑ Decline to Answer

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill	**Birth date**	**Address (if different)**	**Phone**
	/ /		( )

Name of Primary Insurance Company	**Subscriber's name**	**Birth Date**	**Policy #**	**Group #**
		/ /		

Patient's relationship to subscriber ❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Other**

Name of Secondary Insurance Company	**Subscriber's name**	**Birth Date**	**Policy #**	**Group #**
		/ /		

Patient's relationship to subscriber ❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Other**

IN CASE OF EMERGENCY

Emergency Contact Name	**Relationship to patient**	**Primary Phone**	**Secondary Phone**
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize O & O Alpan, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***