Vivid Health

Patient Information:

Name (Last, First, Initial): _____

Address: _____

Zip, City, State: _____

Home Number: _____ Cell Number: _____

Patient Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Other

Birthdate: _____ Sex: ____ Social Security Number: _____ Email: _____

Primary Care Dr: _____ Referred By: _____

Allergies _____ Pharmacy _____

Guarantor Information/ Secondary Address:

Name: _____ Phone # :_____

Address: _____ Social Security #: _____

Employment Status: [ ] Full-time [ ] Part-time [ ] Not Employed [ ] Retired [ ] Student

Employer's Name: _____ Phone #: _____

Address: _____

Insurance Information:

Primary Insurance: _____

Address: _____ Phone #: _____

Policyholder's Name: _____ Policyholder's B-day: _____Sex: _____

Social Security #: _____ Policy Number: _____ Group #: _____

Primary Reason for Today's Visit: _____

_____

_____

_____

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I also authorize the physician to release any information required to process this claim and in the course of my exam and treatment

SIGNED _____ **Date** _____