PATIENT INFORMATION (Please Print & Complete Entire Form) Today's Date ___/___/___

Name_____
Last *First* *M.I.*
Mailing Address_____
City *State* *Zip*
Home Phone_____ Work Phone_____ SS#_____
Area Code *Area Code*
Employer Name _____ Address, City, State, Zip _____

Date of Birth ____/____/____ Age_____ Sex_____ Ethnicity/ Race_____ Martial Status _____

Drivers License #_____ (Please provide Drivers License to Receptionist for copying) State_____

Preferred Phone for text and automated appointment confirmation (_____)_____

PARENT OR RESPONSIBLE PARTY (if different from the patient)

Name_____
Last *First* *M.I.*
Mailing Address_____
City *State* *Zip*
Home Phone_____ Work Phone_____ SS#_____
Area Code *Area Code*
Date of Birth ____/____/____ Sex_____

INSURANCE INFORMATION (Please present insurance card at time of check in). ***Note: We do not participate, bill or accept payment from Tricare, Medicaid, Soonercare or Oklahoma Health "High Risk Pool" Insurance. (Please complete All Entries)***

Primary	**Secondary**
Insurance Name_____	Insurance Name_____
Ins. Address_____	Ins. Address_____
Name of Employee_____	Name of Insured_____
Insured's ID# _____	Insured's ID#_____
Group # _____ Date of Birth_____	Group # _____Date of Birth _____
Employer Name _____	Employer Name _____
Employer Address _____	Employer Address _____
Employer Phone _____	Employer Phone _____
Relationship of patient to the Insured _____	Relationship of patient to the Insured _____
Guarantor Social Sec#_____	Social Security#_____
Copay Amount _____	Copay Amount_____

I authorize (BTHD) to leave message or discuss medical account and medical care Y or N (Please Circle)

Authorized to discuss medical & account information with:_____Relation_____

Other family members that are patients _____

In case of Emergency, who should be notified? _____Phone_____

Referred by: _____Phone_____

Primary Care Physician _____Phone_____

EMAIL ADDRESS:_____

ASSIGNMENT AND RELEASE: By signing this form, I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. ***If my account is sent to a collection agency, I agree to pay all collection and attorney fees.*** **I also authorize the release of medical information of my care to referring physician, or consultants if needed and as necessary.**

Responsible Party Signature (Required/no initials) _____ ***Date*** _____