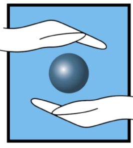

PATIENT INFORMATION

First Name ______________________________MI ______Last ______________________________

What do you prefer to be called? ____

Street Address ____

City ______________________________________State __________Zip Code ____________________

Phone: ________________ Email: ____

Date of Birth __________Age _____Gender ________________Martial Status____________________

Do you have power of attorney / Guardian? Yes__ No__ If yes, Name____________________________

Emergency Contact / Relationship to Patient? ____

PRIMARY INSURANCE COMPANY ____

Subscriber ____Date of Birth _______________________

Relation to Subscriber ____

Identification Number ______________________________Group Number ______________________

SECONDARY INSURANCE COMPANY ____

Subscriber ____Date of Birth _______________________

Relation to Subscriber ____

Identification Number ______________________________Group Number ______________________

I hereby authorize Laurel Holze, PA-C, MPH to furnish my insurance company all information which the insurance company may request concerning my present illness. I hereby assign Laurel Holze, PA-C, MPH all monies to which I am entitled for expenses relative to the services received. I understand that I am financially responsible to said clinician for charges not covered by this assignment.

____Date ____________________

Signature of Patient or Legal Guardian