CLIENT INFORMATION

Today's Date: _____ /_____ /_____

CLIENT INFORMATION: ***Please Print***

Legal First Name:______________________________ MI:_____ Last Name:______________________________

Preferred Name:______________________________ Date of Birth: _____ /_____ /_____

Address:______________________________________ City:___________________ State:_____ Zip Code:___________

Mobile Phone: ( ) _________ -____________ May we leave messages? ☐Yes ☐No

Home/Work Phone: ( ) _________ -____________ May we leave messages? ☐Yes ☐No

Email Address:____ Email Appt Reminders? ☐Yes ☐No

Birth Sex: ☐Male ☐Female ☐Other Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Employer/School & Grade:____

Insurance Provider:_______________________ ID#:_____________________________ Group#:________________

IN THE EVENT OF AN EMERGENCY, AFC may contact:____

Relationship to Client:__________________ Phone Number: ( ) _________ -____________

RESPONSIBLE PARTY (Guarantor) PERSONAL INFORMATION: ***only if different than client***

Legal First Name:______________________________ MI:_____ Last Name:______________________________

Relationship to Client:__________________ Date of Birth: _____ /_____ /_____ **☐Address Same As Above**

Address:______________________________________ City:___________________ State:_____ Zip Code:___________

☐Same As Above Mobile Phone: ( ) _________ -____________ Leave messages? ☐Yes ☐No

☐Same As Above Home/Work Phone: ( ) _________ -____________ Leave messages? ☐Yes ☐No

☐Same As Above Email Address:____ Appt Reminders? ☐Yes ☐No

I authorize the release of any information necessary to process claims with my insurance company. I authorize my insurance company to make payments for my treatment directly to Associates in Family Care. I understand that I am responsible for paying my deductible/co-pay (where applicable). I understand a third party is used for this purpose. I authorize the release of information to the third-party biller "Practice Management Solutions Consultants" for the purposes of billing.

Signature:____ Date: _____ /_____ /_____

PLEASE NOTE: We **do not** bill secondary insurance. If you choose to submit on your own, you must use the Explanation of Benefits statement sent by the primary insurance company to your address.