University Medical Professionals

PATIENT INFORMATION

Name: Error Test	**Date of Birth:**
Address One:	**Social Security #:**
Address Two:	**Sex: M**
City:	**PCP/Ref Dr.:**
State: Zip:	**Employer:**
Home Phone#:	**Emergency Contact:**
Work Phone#:	**Emergency Phone#:**
Cell Phone#:	**Emergency Relationship:**

How did you hear about our office? _____

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	
City:	**Employer:**
State: Zip:	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State: Zip:**
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, University Medical Professionals when they accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, University Medical Professionals to release any information necessary for my course of treatment.

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Signed (patient or parent if minor) Date