

**Outpatient Information / Consent to Treat**

<b>PATIENT INFORMATION</b>		Account #:	Medical Record #:	Date:	
Patient Name:			Referring Doctor:		
Address:			Referring Doctor Phone #:		
City/State/Zip:			Primary Doctor:		
Home Phone:		Work Phone:	Employer/School:		
Social Security #:		Date of Birth:	Age:	Marital Status:	Sex:
Emergency Contact:		Relationship:	(H) Phone #:		(C)
Responsible Party:		Relationship:	DOB:	SS#:	
Responsible Party Address:			City/State/Zip:	Phone #:	
<b>INSURANCE INFORMATION</b>					
Primary Insurance:		Employer:	Secondary Insurance:		Employer:
Insurance ID #:		Insurance Group #:	Insurance ID #:		Insurance Group #:
Insured Name:			Insured Name:		
Address:			Address:		
City/State/Zip:			City/State/Zip:		
Insured DOB:		Insured Social Security #:	Insured DOB:		Insured Social Security #: