Thank you for choosing Elite Healthcare Center. To better serve you, please provide the following information:

Patient Information **SSN:** _____

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Cell _____ Gender: _____

E-Mail Address: _____ May we contact you by e-mail? Yes No

Would you like to use this e-mail address to access a secure online portal for Elite Healthcare patients? Yes No

How did you hear about us? _____

Employer

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Primary Policy Holder's Information/Responsible Party

Policy Holder (Name): _____ Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Relation to Patient: _____ Policy Holder's SSN: _____ DOB: _____

Policy Number: _____ Group Number: _____

I authorize the release of information concerning my healthcare and treatment for the purposes of evaluating and administering claims of insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me directly, to the Physician. Elite Healthcare Center will file a claim with your insurance company for services performed. In the event of non-payment, I understand that I will be responsible for charges incurred today and any legal fees, collection fees, or other expenses incurred by Elite Healthcare Center in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

_____ Date: _____

(Signature of patient)