



North OKC
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Suite 200
Oklahoma City, OK 73114

(405) 433-4224 phone
(405) 493-0717 fax

Downtown OKC
1000 N. Lincoln Blvd
Suite 3600
Oklahoma City, OK 73104

New Patient Information

Please print - fill in all blanks

Patient's name _____

Gender _____ Date of birth _____ SSN# _____

Patient's address _____

Phone#1 _____ #2 _____ email _____

Preferred language _____ Referring physician/pediatrician _____

phone#

Insurance Information

We will need a copy of the insurance card in order to file a claim

Primary Insurance Company _____ ID# _____ Group# _____

Policy holder name _____ Relationship to patient _____

Policy holder's DOB _____ Policy holder's SSN# _____ Employer _____

____N/A Secondary Insurance Company _____

Policy holder name _____ Relationship to patient _____

Policy holder's DOB _____ Policy holder's SSN# _____ Employer _____

Guarantor Information

Name _____ Date of Birth _____ SSN# _____

Patient's address _____ Phone# _____

Employer _____ Phone# _____

Employer's address _____

city

state

zip

I authorize the release of any medical information if necessary to file insurance claims. I authorize payment of medical benefits to the undersigned provider for the services rendered. I accept responsibility for full payment on my account. I acknowledge and agree that I have received a copy of the Notice of Privacy Practices.

Signature

Date