



EMERALD SPRING CLINICS

PATIENT INFORMATION

DOB (mm/dd/yyyy)

/ /

Gender

☐ M

☐ F

Social Security No.

Patient ID #:

NEW

Salutation

Last Name

First Name

MI

Suffix

Patient Address

City

State

Zip

Home Phone

Work Phone

Cell Phone

Email



Patient Photo

JR
SR
III



2X2 Photo

Add Pic

Marital Status

☐ Single

☐ Married

☐ Other

Partner Name

Emergency Contact Name

Employer Name

Emergency Contact Phone

I Will be paying today by: (Please Check One Box)

- ☐ Having Emerald Spring Clinics file my insurance for me and I will pay my COPAY today.
- ☐ Paying for my office visit today with Cash, Check, or Credit Card.

I authorize the release of any medical information necessary to process claims and irrevocably assign to Emerald Spring Clinics all payments for services rendered. I understand that I am ultimately responsible for the balance of my account, whether or not any of the professional services rendered are covered by my insurance. I understand that my appointment will need to be rescheduled if I do not have my COPAY, my insurance information, or payment for my office visit today. I certify that this information is true and correct. I have received a copy of the Privacy Notice and have had an opportunity to object to the disclosures of my health care information.

SIGNATURE (if minor, Parent's Signature)/ DATE

Thank you for choosing Emerald Spring Clinics!