Date of Appointment:

____

First Name: _________________________________ MI ______ Last Name: ______________________________________ M / F

SSN: ___________________ Birthdate: ______________ Age: _____ Sin / Mar / Div / Wid Spouse/Sig Other Name: ___________

Address: ____ City: _____________________ State: ______ Zip: _______________

Home Phone: ___________________________ Cell Phone: _________________________ E-Mail: __________________________

Preferred Method of Contact: Home Phone / Cell Phone / Work Phone / E-Mail / Text

Employer: ____________________________________ Occupation: __________________________ Work #: _________________

Spouse Phone: ________________ Spouse Employer: ___________________________ Spouse SSN: _________________________

Other Emergency Contact: ___________________________________ Phone: ____________________ Relation: ______________

Primary Doctor: ____________________________________ **Referring Doctor:** ____

Race: American Indian / Asian / African American / White / Other / Decline to Answer. ___________________________________

Ethnicity: Are you Hispanic or Latino? Y /N / Decline to Answer.

Language: English / Spanish / French / Arabic / Other ____

☐ Self (If self, skip this section) Patient Relationship to Responsible Party ☐ Spouse ☐ Father ☐ Mother ☐ Child ☐ Other_________________

Name: ____ SSN: _________________________ DOB: ________________________

Home Phone: __________________________ Cell Phone: ________________________ E-Mail: ____________________________

Address: ________________________________ City: _____________________________ State: ________ Zip: _______________

Driver's Lic #: ____________________________ Employer: ________________________________ Work #: __________________

☐ The above named patient is either a minor or under 19 or an incapacitated adult requiring diagnosis and treatment. As legal guardian, I consent to such diagnostic procedures and treatments as necessary in the judgement of the doctors at GSA and/or their assistants by signing below.

Primary Insurance: ______________________________________ Policy Holder: ____

If Policy Holder other than Patient: Policy Holder DOB: _________________________ Policy Holder SSN: ____________________

Policy Holder Relation to Patient: ____________________________ Policy Holder Phone #: ________________________________

Policy Holder Address: ____

Policy Holder Employer: ____ Work #: _____________________________________

Secondary Insurance: ____ Policy Holder: ____________________________________

If Policy Holder other than Patient and different from above: DOB: _____________________ SSN: _________________________

Policy Holder Relation to Patient: _______________________ Policy Holder Phone #: ____________________________________

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for the recommended services performed that are not covered under the terms of my health plan. I authorize the physician to release any medical information required to process this claim. I authorize my provider's office to contact me by telephone to remind me of my appointments.

Signature of Legal Responsible Party: ____ Date: __________________________