AdexonCare
COMPASSION
INTEGRITY ACCESSIBLE

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PATIENT INFORMATION FORM

Patient Name			Social Security Number
Date of Birth	Marital Status S M D W P	Address	
Home Phone	Ok to leave message? Yes No	City State Zip Code	
Email Address		Employer's Name/Occupation	
Mobile Phone or Pager		Work Phone Ok to leave message? Yes No	
Emergency Contact	Relationship	Emergency Contact Phone	
Primary Care Physician		**Insurance** Name of Insurance co. _____	
Pharmacy with two cross streets		ID# _____	
How were you referred to our practice? ☐ Newspaper ☐ Friend ☐ Internet ☐ Sign/Drive Bye ☐ Yellow pages ☐ Other_____		Group# _____ Phone# _____	

Parent/Guardian or Primary Insured Info (if patient is a minor or is not the primary insured)

Parent/Guardian or Primary Insured Name			Social Security Number
Date of Birth	Relationship to patient	Address *(if different from above)*	
Home Phone		City State Zip Code	
Work Phone		Employer's Name	

----------Please read below and sign----------

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Adexon Care for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance

Signature of Responsible Party: _____ Date: _____

Record Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ Date: _____