A. IDENTIFICATION

Name (Last) (First) (Middle)			
Maiden Name			
Primary Address			
City	State	Zip Code	Country
Alternate Address			
City	State	Zip Code	Country
Home Phone	Work Phone		
Cell Phone	E-mail Address		
Date of Birth	❒ Male	❒ Female	
Height / Weight	Eye Color	Hair Color	
Ethnicity/Race	Birthmarks/Scars		
Blood/RH Type	Special Conditions	Marital Status	
Occupation			
Company Name			
Address			
City	State	Zip Code	Country
Phone Number	Languages Spoken - Primary and Secondary		
Primary Health Insurance Carrier	Policy Number		
Secondary Health Insurance Carrier	Policy Number		
Spouse's Name			
Occupation			
Social Security Number	Date of Birth		

B. EMERGENCY CONTACTS

In Case of Emergency, Notify: Primary Contact

Name (Last) (First) (Middle)			
Relationship			
Address			
City	State	Zip Code	Country
Home Phone	Work Phone		
Cell Phone	E-mail Address		

In Case of Emergency, Notify: Secondary Contact

Name (Last) (First) (Middle)			
Relationship			
Address			
City	State	Zip Code	Country
Home Phone	Work Phone		
Cell Phone	E-mail Address		

In Case of Emergency, Notify: Medical Contact

Physician (Indicate Specialty)	
Phone	
Dentist	Phone
Pharmacy	Phone

LIFETIME AUTHORIZATION

Insurance and/or Medicare certification for payment

I certify that the above information given by me in applying for payment under Title XIX of The Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration of its intermediaries or carrier any information needed for this or related insurance claims. I request that the payment of authorize benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment. I authorize the release of any medical information necessary for insurance claim processing. I authorize payment of medical benefits of The Breast Clinic.

Signed: _____ Date: _____

By: _____ Relationship: _____

If signed by other than beneficiary, state the reason the patient was unable to sign: _____