

Patient Information  
Ira Chiro P.C.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt # City State Zip

Phone Numbers: \_\_\_\_\_  
Home Work

Sex: Male Female Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Single Married Spouse's Name: \_\_\_\_\_

Spouse's Birthdate: \_\_\_\_\_ Spouse's SS#: \_\_\_\_\_

In case of emergency, contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Insurance Information

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Card Holders Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_ Plan Code: \_\_\_\_\_

Additional Insurance

Insurance Company Name: \_\_\_\_\_

Card Holders Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_ Plan Code: \_\_\_\_\_

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with

\_\_\_\_\_ and assign directly to Dr. Smith, Ira Chiro P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship if legal guardian:  
\_\_\_\_\_