



**Patient Information**

**Name** (last, first):

**Street Address:**

**City, State, Zip:**

**E-Mail Address:**

**Emergency Contact:**

**Date of Birth:**

**SS#:**

**Home Phone:**

**Work Phone:**

**Cell Phone:**

**Phone:**

**Sex:** Male  Female

**Marital Status:** Married  Single  Divorced

Widowed  Separated

**Employer's Name:**

**Phone:**

**Relationship to Insured:** Self  Spouse  Child  Other

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**Health Insurance Information (primary)**

**Health Insurance Name:**

**ID#:**

**Group#:**

**Address:**

**Plan Name or #:**

**Name of Insured:**

**Birth Date:**

**SS#:**

**Relationship to Insured:** Self  Spouse  Child  Other

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**Health Insurance Information (secondary)**

**Health Insurance Name:**

**ID#:**

**Group#:**

**Address:**

**Plan Name or #:**

**Name of Insured:**

**Birth Date:**

**SS#:**

**Relationship to Insured:** Self  Spouse  Child  Other

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**Financial Responsibility** (Person responsible for Patient Named Above)

I authorize the release of any information necessary to process medical claims for the patient named above and authorize that payment of benefits for these claims be made to CanThera. Also, I agree to promptly pay for any services not covered by my insurance and or determined by my insurance company to be my responsibility (i.e., deductibles, co-payments and any charges for services and/or laboratory tests not covered or deemed "Not Reasonable and Necessary.

\_\_\_\_\_  
Signature of Guarantor

\_\_\_\_\_  
Date

Relationship to Insured: Self  Spouse  Child  Other

\_\_\_\_\_  
Referring Physician:

\_\_\_\_\_  
Phone:

How did you hear about us? Doctor  Internet  Friend  Other