RSH LLC
DBA SONORANMD

Date:_____

Patient Name: _____

(Last) (First) (Middle)

Mailing
Address: _____City: _____ ST:_____Zip:_____
SS#_____ DOB:_____ AGE:_____
HM#_____ Cell#_____ WK#_____
Race: White___ Asian:___ African American:___ American Indian:____ Hispanic:___ Other:___
Email: _____ May we contact you: YES___ NO___
Marital Status: Single Married Divorced Widow Male/Female_____

Referring Physician: _____ Phone: _____
Emergency Contact: _____ Relationship: _____ Ph#_____
Pharmacy: _____ Location: _____ PH# _____
Patient Employer: _____

Please Complete if the Patient is a Minor:

Responsible Party: _____ Relation to Patient _____
Address: _____City _____ State _____ Zip _____
Do we have permission to treat the minor child in your Absence? Yes__ No__
Signature of Guardian: _____

INSURANCE INFORMATION **Is this work related? _____**

Primary
Insurance: _____ Policy Holder: _____ DOB:_____ Relationship_____
Ins Ph#_____ Policy Holder Employer: _____ Wk# _____
Policy ID _____ Group# _____

Secondary
Insurance: _____Policy Holder_____ DOB: _____ Relationship: _____
Ins Ph# _____ Policy Holder Employer_____ Wk# _____
Policy ID# _____ Group# _____
Address: _____ City: _____ ST_____ Zip: _____

Assignment and Release:
I hereby agree to accept financial responsibility for all the charges incurred in the course of my treatment. In the case of Medicare or other insurance that the practice have executed an agreement with, I understand that I am responsible for paying any deductible, non-covered items, or copayments required under the term of my insurance plan. There is a fee of 25.00 for a no-show appointment or cancellation of less than 24-hour notice. Hould collection procedures become necessary, I agree to pay the collection agency's cost and/or reasonable attorney fees. I hereby authorize the practice to bill my health insurance plan. I hereby authorize the release of information acquired in the course of the exam and treatment, should it become necessary to secure payment if benefits.

Signature of Patient or Responsibility Party: _____ Date: _____