

**Patient Information**

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Sex M / F  
Street or P O Box City State Zip Code

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's Lic. #: \_\_\_\_\_ Martial Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**IF PATIENT IS A MINOR OR RESIDES WITH PARENTS, PLEASE COMPLETE THE FOLLOWING:**

Father's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**INSURANCE INFORMATION – PLEASE PROVIDE CARE SO THAT WE MAY MAKE A COPY**

Insurance #1: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

Insurance #2: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

Guarantor: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

Address if different: \_\_\_\_\_  
Street or P O Box City State Zip Code

Is this an accident that occurred during school sports? YES / NO If yes, date: \_\_\_\_\_

Is this a worker's comp accident? YES / NO If yes, date: \_\_\_\_\_

If accident, is there an attorney involved? YES / NO If yes, attorney name: \_\_\_\_\_

In case of emergency, please notify \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Who referred you to this practice? \_\_\_\_\_

**Assignment of Insurance Benefits**

I hereby authorize assignment of my medical and/or surgical benefits to include major medical benefits that I am entitled, private insurance, Medicare, and any other health plans to my physician at Daniel L. Munton, M.D PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance

\_\_\_\_\_  
Signature of Patient or Parent/Legal Guardian if under 18 years of age Date