345 N. Main St., Suite 306
West Hartford, CT 06117
860-233-8803

Patient Name: ____ **DOB:**________________________________

PERSON RESPONSIBLE FOR PAYMENT (GUARANTOR)

Name of Responsible Person: _________________________ _______________________________________
(Relationship to Patient)

Responsible Person SSN#: ____________________________ **Date of Birth:** __________________________

Home Address: ____
(Street) (City) (State) (Zip) (Home Telephone)

Employer Info: ____
(Employer) (Employer Street Address) (City) (State) (Zip)

Employer Phone Number:___________________________ **Circle One: Full Time Part Time**

Email Address:______________________________________ **other email:**_____________________________

INSURANCE INFORMATION (List All Insurance You Are Covered By)

Primary Insurance: _________________________ **Plan Name:** ______________ **Employer:**_________________

Claims Address: ____
(Street) (City) (State) (Zip)

Name of Subscriber: ______________________ **DOB:**___________ **Relationship to Patient:** ________________

Insurance ID#: ______________________ **Group #:** ______________________ **SSN#:** ________________________

Secondary Insurance: _______________________ **Plan Name:** ______________ **Employer:**_________________

Claims Address: ____
(Street) (City) (State) (Zip)

Name of Subscriber: ______________________ **DOB:**___________ **Relationship to Patient:** ________________

Insurance ID#: ______________________ **Group #:** ______________________ **SSN#:** ________________________

PLEASE NOTE: *Full payment (or co-payment) is required at the time of visit: Master Card, Visa and Discover Card are accepted. An Administrative fee will be charged for appointments canceled without 24-hours advance notice.*

OTHER HEALTH INSURANCE

Name of Insurance Company:_____________________________ **Employer or Group Name:** _______________

Group or Policy Number:_________________ **Subscriber's Name (as appears on card)**____________________

Subscriber's Relationship to Patient: ________________ **Subscriber's SSN#:**_____________________________

Insurance Billing Address: ____

(Street) (City) (State) (Zip)