Name:	Date:
*__SSN__: - -	***Primary Language:***
State of Birth: ***Date of Birth:***	***Special Needs:***
How would you prefer to be contacted? (select below)	***Race:***
Home ***Work*** ***Cell*** ***US Mail*** ***Email***	***Ethnicity:*** *(select **one** option below)*
Email:	Unknown Not Hispanic or Latino Hispanic or Latino
Have you had any changes in your information or insurance?	Occupation:
If yes, please explain:	Employer:
Have you had any changes in your medication(s)?	***Mother's Maiden Name:***
If yes, Please explain:	Primary Care Doctor:

***Emergency Contact Name**: **Phone Number**: ☐ Home ☐ Cell **Relationship**:

Billing Agreement / Authorization

I authorize the office of Dr. Scott R. Brizius and Dr. Stacey O. Embry to bill my insurance and I fully understand that I am responsible for the balance that is not covered by said insurance.

Should my balance become overdue and require the use of a collection agent, I authorize the office to contact me by any telephone number I provide to you, email, text message, or postal mail regarding my account.

Some insurance companies (Anthem included) have contractual charges that they see as not necessary. Should my insurance deem certain charges not necessary or covered for whatever reason, I agree to pay those charges in full.

Printed Patient Name _____

Signature _____ Date _____/_____/_____

(Parent/Guardian Signature if patient is under 18 years of age)

*****This information is that which we are required by the government to obtain from you.*****

Have you had any surgeries since last exam? _____

Have there been any changes in your family's medical history?_____

Any other changes that we should be aware of? _____