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Patient Name: ____
(First) (Middle Initial) (Last)

Age: __________ Date of Birth: ______________________ Sex:________M__________or__________F____

Address:____

City: _______________________________________ State: __________________ Zip: _____________________

Phone
Home: ________________________ Work: ________________________ Cell: __________________________

Email Address: ____

Employer: ____

Employer Address: ____

Primary Care Physician: ____

Person to Contact in Case of Emergency: ____
Relationship: ________________________________ Phone: ____

**How would you like to receive recall notifications?

______Email ______Phone ______Postcard

Whom may we thank for referring you? ____

Medical Authorization – Assignment of Benefits
I hereby authorize the release of any medical information necessary to process claims for any and all professional services rendered by Alan Ecker, M.D. and Patricia Ecker, M.D.

I authorize the payment of any benefits due to Alan Ecker, M.D. and Patricia Ecker, M.D. and understand any copays, deductibles, and denied services will be the patient’s responsibility.

Signed: ____ Date: ___________________________