JACKSONVILLE IMPOTENCE TREATMENT CENTER

PLEASE PRINT CLEARLY

Please present insurance
card and photo ID for us to copy

Date _____

Primary Care Physician

_____

Name:_____
Street Address: _____
City, State and Zip: _____
Home Phone #: _____Work #:_____ _____
Cell Phone #: _____
Social Security Number #: _____
Date of Birth: _____Sex: _____
Marital Status: _____
Employer Name: _____
Employer Address:_____

Emergency Contact Information

Contact Name: _____
Relationship to _____
Patient:Address: _____
Home Phone #:_____ Work *it:*_____

Primary Insurance Information:

Insurance Company Name: _____
Policy Number:_____
Social Security Number: _____
Group Number: _____
Insurance Filing Address: _____ City, State, Zip Code _____
Insurance Phone Number: _____

Secondary Insurance Information:

Insurance Company Name: _____
Policy Number:_____ _____
Social Security Number: _____
Group Number: _____
Insurance Filing Address: _____ City, State, Zip Code _____
Insurance Phone Number:

Referred By: _____