Patient Information

First Name: _____ Last Name: _____

Home Phone: _____ Cell: _____

Email:_____ SSN:_____

Preferred Pharmacy: _____

Preferred Lab: _____

Preferred Imaging center: _____

Emergency Contact: _____

Relation: _____ Phone Number: _____

Responsible Party Name: _____ Date of Birth: _____

I authorize the release of any medical information needed to determine medical benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby consent to routine diagnostic procedures and medical treatment provided through NAB Life Health and understand that no guarantee of results has been made.

Signature (Responsible Party):_____Date:_____