PATIENT INFORMATION

In order to serve you properly, we need the following information. PLEASE PRINT. All information will be confidential.

Patient Name _____
First Middle Last

Patient Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____ Other _____

SSN _____ ❑ Male ❑ Female Birth date _____ Age _____

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient Employer _____ Occupation _____

Spouse Name _____ Employer _____ Work Phone _____

Person we are allowed to discuss your medical records with: _____ Phone: _____

Person to contact in case of an emergency: _____ Phone: _____

IF PATIENT IS A MINOR

MINOR LIVES WITH: ❑ BOTH PARENTS ❑ MOTHER ❑ FATHER ❑ OTHER _____

Father's Name _____ Address _____ Hm Phone _____
(if different than the patients)

Father's Employer _____ Occupation _____ Wk Phone _____

Mother's Name _____ Address _____ Hm Phone _____
(if different than the patients)

Mother's Employer _____ Occupation _____ Wk Phone _____

INSURANCE INFORMATION

Check appropriate box: ❑ Group Insurance ❑ Workman's Compensation ❑ Personal Injury/Accident

Primary Insurance

Policy Holder _____ Relationship to Patient _____

SSN _____ Date of Birth _____

Insurance Company _____ ID# _____ Group# _____

Secondary Insurance

Policy Holder _____ Relationship to Patient _____

SSN _____ Date of Birth _____

Insurance Company _____ ID# _____ Group# _____

WE WILL FILE YOUR INSURANCE CLAIM FOR OUR SERVICE. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER. WE ARE NOT A PARTY TO THAT CONTRACT. IN SOME CASES IF YOUR INSURANCE COMPANY HAS NOT PAID YOUR ACCOUNT WITHIN 45 DAYS FROM BILLING DATE, IT WILL BE **YOUR** RESPONSIBILITY TO MAKE PAYMENT ARRANGEMENTS. BALANCES AFTER INSURANCE PAYS IS DUE 30 DAYS AFTER PAYMENT UNLESS PREVIOUS ARRANGEMENTS ARE MADE.

SIGNATURE _____ DATE _____
Signature of patient or guardian

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTH CARE, ADVICE AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATION AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I ALSO AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR.

SIGNATURE _____ DATE _____
Signature of patient or guardian