

PATIENT INFORMATION

(Please Print)

Today's Date ____/____/____

Name _____

Last

First

M.I.

Mailing Address _____

Home Ph. _____ Work Ph. _____ Cell Ph. _____
Area Code Area Code Area Code

Any Restrictions for contacting you? No Yes E-mail _____

Contact Restrictions: _____ Is it okay to call you at work? Yes No

Date of Birth ____/____/____ Age _____ Sex _____ Marital Status _____ SS# _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____

Last

First

M.I.

Address _____

Home Ph. _____ Work Ph. _____ Cell Ph. _____
Area Code Area Code Area Code

Date of Birth ____/____/____ Sex _____ SS# _____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____

Secondary Insurance Name _____

Ins. Address _____

Ins. Address _____

Name of Insured _____

Name of Insured _____

Insured's ID# _____

Insured's ID# _____

Group # _____

Group # _____

Employer Name _____

Employer Name _____

Employer Address _____

Employer Address _____

Employer Phone _____
Area Code

Employer Phone _____
Area Code

Relationship of patient to the Insured _____

Relationship of patient to the Insured _____

Pharmacy of choice _____ Phone _____

In case of Emergency, who should be notified? _____ Phone _____

How did you hear about us? _____

Primary Care Physician _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date ____/____/____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you have a contracted insurance. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event that your account must be turned over to collections, a \$50.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date ____/____/____

Copy of insurance card (both sides) attached.

Updated By: _____