

PATIENT INFORMATION

Patient Name: _____
Last First Middle Initial

Age: ____ Birth Date: ____/____/____ Gender: M/ F Patient SS #: ____-____-____ Marital Status: S/ M / Sep/ D/ W

Address: _____ Home Phone (____)____-____ Cell Ph (____)____-____
_____(city, state, zip) Work Ph (____)____-____

Email address: _____

Employer: _____ Position: _____ Business Ph (____)____-____

Person Responsible for Account: Self/ Spouse/ Father/ Mother/ Other: _____
SS #: ____-____-____
Last First Middle Initial

Spouse's Name: _____
Last First Middle Initial

Spouse's Employer: _____ Position: _____ Business Ph (____)____-____

Referring Physician: _____ Referring Doctor's Phone: (____)____-____

PRIMARY INSURANCE

Insurance Company: _____ Type: HMO / PPO / Other _____ Visit Copay: \$ _____

Policy ID #: _____ Group #: _____ Insurance Ph (____)____-____

Policy Holder Name: _____
Last First Middle Initial

Relation to Patient: _____ Birth Date: ____/____/____ Gender: M / F

Policy Holder Address: _____
**If different from above _____

Policy Holder's Home Phone (____)____-____ Cell Ph (____)____-____

Policy Holder's Employer: _____ Position: _____

Employment Address: _____ Business Ph (____)____-____

EMERGENCY CONTACT INFORMATION

Contact Name: _____
Last First Middle Initial

Address: _____ Home Phone (____)____-____ Cell Ph (____)____-____
_____ Other Phone (____)____-____ Work Ph (____)____-____

PHARMACY NAME: _____ **ADDRESS:** _____
PHONE: _____ **FAX:** _____

ASSIGNMENT AND RELEASE

1. I am responsible for the balance of my account for any professional services rendered. I certify that this information is correct to the best of my knowledge. I will notify you of any changes at subsequent visits.
2. I authorize the release of any medical or other information necessary to process the insurance claims.
3. I authorize payment of medical benefits to the physician directly.
4. There is a \$25.00 cancellation fee for missed office appointments. If an appointment is missed with no notification, the patient will be charged \$25.00.

Responsible Party's Name _____ Responsible Party's Signature _____

Relationship _____ Responsible Party's Driver's License #: _____