PATIENT INFORMATION

(*Please Print)* Today's Date ____/____/_____

Name_____
Last *First* *M.I*

Mailing Address_____
Street Address *City* *State* *Zip*

Home Phone _____ Work Phone _____ Cell Phone: _____ SS#_____

Date of Birth ____/____/_____ Age_____ Sex_____ Martial Status: ❑ *M* ❑ *S* ❑ *D* ❑ *W*

Email Address _____ Drivers License#_____

❑ You may use my email address to contact me regarding office updates & specials.

PARENT OR RESPONSIBLE PARTY (*if different from patient)*

Name_____
Last *First* *M.I*

Mailing Address_____
Street Address *City* *State* *Zip*

Home Phone _____ Work Phone _____ Cell Phone: _____SS#_____

Date of Birth ____/____/_____ Age_____ Sex_____ Drivers License #_____

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

Primary Insurance Name_____
Ins. Address _____
Name of Insured _____
Insured's DOB_____
Insured ID# _____
Group# _____
Employer Name _____
Employer Address _____
Employer Phone_____
Relationship of patient to insured_____

Secondary Insurance Name_____
Ins. Address _____
Name of Insured _____
Insured's DOB_____
Insured ID# _____
Group#_____
Employer Name _____
Employer Address _____
Employer Phone_____
Relationship of patient to insured_____

Other family members that are patients_____

Pharmacy of choice_____ Phone_____ Fax_____

In Case of Emergency _____Phone_____ Cell _____

Person who I agree to release medical information to: _____ Phone _____
Name

Primary Care Physician _____

Referred by: ❑ MD ❑ Family/Friend ❑ Magazine ❑ Radio ❑ Mailer ❑ Website

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 are in a prepaid plan in which we participate. 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 of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay the unmet deductible, non-covered sources, and co-payments. In the event that your account must be turned over to collections, a $20.00 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: _____

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