

PATIENT INFORMATION FORM

PATIENT INFORMATION

Minor Single Married Divorced Widowed

Last Name: _____ First: _____ M.I. _____ Sex: M F
Social Security # _____ Date of Birth: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home # _____ Cell # _____ Email _____
Name of Employer: _____ Phone: _____

POLICY HOLDER (If different from Patient)

Last Name: _____ First: _____ M.I. _____ Sex: M F Social
Security # _____ Date of Birth: _____ Driver's License # _____
Address: _____ Home #: _____ Cell #: _____
Name of Employer: _____ Phone: _____

SPOUSE INFORMATION (If different from above)

Last Name: _____ First: _____ M.I. _____ Sex: M F Social
Security #: _____ Date of Birth: _____ Driver's License #: _____
Address: _____ Home# _____ Cell #: _____

GENERAL INFORMATION

Previous Physician Name: _____ Phone: _____
Nearest Relative (not living with you) _____ Phone: _____
Incase of Emergency Notify: _____ Phone _____ Relationship: _____

INSURANCE INFORMATION:

Who referred you to our office? (Doctor/Friend/Phonebook) _____ Phone: _____
Primary Insurance Plan: _____ Policy Holder's Name: _____
ID#: _____ Group# _____ Phone: _____
Secondary Insurance Plan: _____ Policy Holder's Name: _____
ID#: _____ Group#: _____ Phone: _____

Financial Agreement: I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection, and attorney's fees. **Assignment of Benefits:** I hereby give lifetime authorization for payment to be made directly to any assisting Physician, for services rendered. I hereby authorize this Healthcare Provider to release all information necessary to secure payment of benefits. I have received and read the Notice of Privacy Practices which advises how you may use and disclose protected information. I agree to the uses and disclosure of my Information for purposes of treatment, payment and practice operations.

HIPAA INFORMATION: Instructions for the office when returning phone calls or reminding you about appointments.

I authorized the office to contact me at: [] Home [] Work [] Cell and May leave messages at: [] Home [] Work [] Cell
I authorize the office to leave detailed messages about appointments/phone calls: [] YES [] NO If you prefer us to leave messages with a specific individual please list them here: 1. _____ 2. _____

Patient (or Parent/Guardian) Signature: _____ **Date:** _____