PATIENT INFORMATION FORM

Please print

NAME _____
Last First M.I.

HOME ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ CELL _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____ M__ F__

SPOUSE'S NAME _____ PHONE _____

PHYSICIAN _____ PHONE _____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY? _____

PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

PHONE _____

OCCUPATION _____ EMPLOYER NAME _____

EMPLOYER ADDRESS _____

INSURED NAME, IF NOT THE SAME :

NAME _____ D.O.B. _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PATIENT RELATION TO INSURED: _____ SELF _____ SPOUSE _____ CHILD _____ OTHER

MEDICARE? _____ YES _____ NO IF YES, NUMBER _____

PRIMARY INSURANCE _____

POLICY NO: _____ GROUP NO: _____

SECONDARY INSURANCE _____

POLICY NO: _____ GROUP NO: _____

HEALTH PROXY: _____YES _____ NO

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

I WILL BE PAYING TODAY BY CASH _____ CHECK _____ CREDIT CARD _____

I authorize any holder of Medical or other information about me to release to the Social Security Administration and Health Care Financing Administrations or its intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account of any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or of changes regarding the above information.

_____ DATE _____
Signature

_____ DATE _____
Parent's (if Minor) /Guardian's Signature